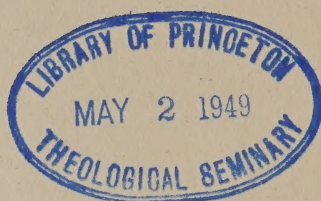


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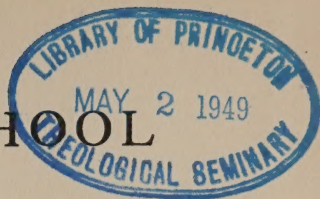


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PROBLEMS OF PRESCHOOL CHILDREN



A BASIS FOR PARENTAL EDUCATION

BY
MARIE AGNES TILSON, PH.D.

TEACHERS COLLEGE, COLUMBIA UNIVERSITY
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M. A. T.

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PROBLEMS OF PRESCHOOL CHILDREN A BASIS FOR PARENTAL EDUCATION

CHAPTER I

INTRODUCTION

A complex of causes has given rise to an increased interest in child care and training in the past few years, and with it has come a demand for parental education. Educators have accordingly been confronted with the problem of determining what the courses in child care and training, especially those dealing with the preschool years, should include. The formulation of such courses requires, of necessity, a knowledge of the problems that arise in the rearing of preschool children and an understanding of the importance of the parents' attitude toward and methods of dealing with these problems.

PURPOSE OF THE STUDY

The purpose of the present study was to discover :

1. The problems¹ that arose in the rearing of 225 American-born children between the ages of one and five years who were referred, for one reason or another, to the seven habit clinics whose records form the basis for the present study. To discover, further: The relation between the problems and the chronological ages and mental levels of the children; the relation between the problems and the nationality, educational training, religion, and occupation of the parents of the children, and the rating of their homes; and the relation between the problems and the number of children in the family and the age position of the problem child in the family.

2. The opinions of specialists concerning the importance of the parents' attitude toward and manner of dealing with their children's problems.

This information, it is hoped, will add to the knowledge upon which parental education courses are based.

¹ "Problem" is used in this study to designate any condition about which the parents either desired or needed help to promote the health and adjustment of their children.

SOURCE OF DATA

The relevant information about the seven habit clinics studied—the name of the clinic, the supporting organization, the location of the clinic, the name of the person in charge, and the number of cases and the time they were treated—is shown in Table 1.

Various publications—books, bulletins, and periodicals—are the source of the data concerning the opinions of specialists with reference to the importance of the parents' attitude toward and manner of dealing with their children's problems.

CRITERIA FOR SELECTION OF CASES

The clinic cases studied were selected upon the basis of the following qualifications:

1. American birth.
2. Age more than one year and less than five years.
3. Physical, psychological, and social history examination data available.
4. Freedom from physical deformity, both congenital and acquired.
5. Mental ability above the level of feeble-mindedness.
6. Home environment, with either parents or foster-parents.

All of the cases fulfilling these requirements were included in the analysis.

The children were of American-born, foreign-born, and mixed parentage and grandparentage. In the case of adopted children, data for the foster-parents are used to secure uniformity, though the clinic records sometimes gave data for both the parents and foster-parents.

The cases were referred to the clinics by physicians, from their private and clinical practice; by public health and board of health nurses, from their districts; by children's aid societies, from their adoption lists; and by parents who wished training advice, assistance with habit correction, or information concerning their children's ability and progress.

The homes of the children were graded either by a scale devised by the clinic to which the children were referred or by a modification of the Whittier Scale for grading home conditions.²

² *Journal of Delinquency*, I (1916): 273-86.

TABLE 1
SOURCE OF DATA

NAME OF CLINIC	ORGANIZATION SUPPORTING THE CLINIC	LOCATION OF CLINIC	PERSON IN CHARGE AT TIME OF TREATMENT	NUMBERS OF CASES	TIME OF TREATMENT
Habit Clinics for Children.	Massachusetts Department of Mental Diseases, Division of Mental Hygiene	Boston	D. A. Thom	50	6/1923-6/1927
Child Guidance Clinic	Commonwealth Fund Community Fund	Cleveland	L. G. Lowrey H. C. Schumacher	15	1/1925-1/1927
Behavior Clinic	City Board of Health	Detroit	Lelah M. Crabbs	30	5/1925-5/1926
Consultation Center	Merrill-Palmer School	Detroit	Helen T. Woolley	59	4/1924-3/1926
Habit Clinic	Children's Hospital of Michigan	Detroit	Irvin H. Neff E. Lee Vincent	15	3/1925-6/1927
Educational Clinic	Institute of Child Welfare Research, Teachers College, Columbia University	New York	Bess V. Cunningham	12	1/1925-8/1926
Habit Clinic	Monmouth County Social Service Organization	Red Bank, N. J.	Ruth Andrus	44	9/1924-8/1926
Total Number of Cases .				225	

The three mental levels, "above average," "average," and "below average," were assigned by each of the clinics on the basis not only of the Terman distribution of the I.Q., but also of the rating on social level, language handicap, emotional attitudes and habits, and educational advantages. The Stanford-Binet, Merrill-Palmer, and Kuhlmann-Binet tests, supplemented in some instances by the Porteus Maze test, Gesell test, and the Goodenough Drawing of a Man test, were used in the clinics.³

The seven clinics represented by the data used in this study treated cases from different types of communities. Four of them treated cases from large city populations; two, cases from city, town, and rural populations; and one, cases from town and rural populations.

The specialists who made the physical and psychological examinations and took the social histories held professional degrees (M.D., Ph.D., or R.N.) that qualified them for their special duties. The registered nurses had had psychiatric social service training in addition to their nurse's training.

³ The mental ratings and home gradings used in this study were made by the clinics to which the children were referred. Since they were made by different people, in different environments, and in the case of the home grading, by different scales, variation in classification may occur. The ratings were made, however, by specialists trained for their particular work, and represent the most nearly uniform data available.

CHAPTER II

HISTORICAL SURVEY OF HABIT CLINICS FOR CHILDREN IN THE UNITED STATES

In the United States, habit clinics for children have been established by state, county, city, and private organizations. Though the names given these clinics vary, the most common are *habit clinic*, *child guidance clinic*, *mental hygiene clinic*, and *behavior clinic*.

The clinics of Pennsylvania, Massachusetts, and Iowa are outstanding examples of habit clinics for children organized and supervised by states. The clinic at Red Bank, New Jersey, supervised by the Monmouth County Social Service Organization, may be instanced as an example of the clinic organized and supported by a county organization. Of those organized and supported by cities, the habit clinic held at the Children's Hospital of Michigan in Detroit and the clinic held in connection with the baby clinics of the same city may be noted. The Yale Psycho-Clinic, the Consultation Center of the Merrill-Palmer School, and the habit clinic of the Institute of Child Welfare Research of Teachers College, Columbia University, are examples of clinics established and operated by private institutions. The Commonwealth Fund, whose headquarters are in New York City, has financed and supervised demonstration habit clinics in various sections of the country which have been taken over, after the demonstration period, by various local organizations.

STATE HABIT CLINICS

The First Habit Clinic in the United States. Dr. Lightner Witmer of the University of Pennsylvania was a pioneer in establishing a clinic on the plan now generally followed—with a staff of medical, psychological, and social specialists in the treatment of children who experience difficulty in adjusting themselves to their life situations. Of the beginnings of his work, Dr. Witmer writes:

In December, 1896, I outlined in an address delivered before the American Psychological Association a scheme of practical work in psychology. The proposed plan of organization comprised:

1. The investigation of the phenomena of mental development in school children, as manifested more particularly in mental and moral retardation, by means of the statistical and clinical methods.

2. A psychological clinic, supplemented by a training school in the nature of a hospital school, for the treatment of all classes of children suffering from retardation or physical defects interfering with school progress.

3. The offering of practical work to those engaged in the professions of teaching and medicine, and to those interested in social work, in the observation and training of normal and retarded children.

4. The training of students for a new profession—that of the psychological expert, who should find his career in connection with the school system, through the examination and treatment of mentally and morally retarded children, or in connection with the practice of medicine.¹

The development of the first clinic Dr. Witmer describes as follows:

A Psychological Clinic has been in operation at the University of Pennsylvania since March, 1896. The following summer, I demonstrated, in the presence of my students in psychology, the abilities and defects of a number of children who began to make more nearly satisfactory progress in school work only after an analytic diagnosis had been made and diagnostic teaching had been prescribed and undertaken. At this time, clinical psychology gained its first adherents from the field of education: Oliver P. Cornman, a supervising principal of a Philadelphia school, who later organized the orthogenic classes of the city; George W. Twitmyer, who made the first clinical examination of the children of a public school system for the purpose of perfecting the educational guidance of a city superintendent; and Mary E. Marvin, a talented teacher of deaf children, who organized and conducted, for the Department of Psychology, in 1897, the first of a number of demonstration classes for the teaching of mentally exceptional children.

In December, 1896, at the annual meeting of the American Psychological Association, I announced my discovery of a method of research and instruction which I called the Clinical Method in Psychology and the Diagnostic Method of Teaching, and I sketched a program of practical work in orthogenics (Witmer, Lightner, "The Organization of Practical Work in Psychology," *The Psychological Review*, 1897, IV, p. 116), some part of which I have been able to realize in the course of a life's work at the University of Pennsylvania. Eleven years later, in 1907, when I began the publication of the results of my clinical research in a journal of orthogenics which I called *The Psychological Clinic*, but one psychological clinic existed—the one which I had founded. Since then, many clinics have been established, some of them called psychological clinics, others educational, orthogenic or child guidance clinics, in such number, indeed, that it would consume much time and patience to discover and name them all.²

¹Lightner Witmer, "Clinical Psychology," *Psychological Clinic*, I, 1 (March 15, 1907): 5.

²Lightner Witmer, "Psychological Diagnosis and Psychonomic Orientation of Analytic Science," *Psychological Clinic*, XVI, 1-2 (January-February, 1925): 17-18.

Habit Clinics in Massachusetts. Since 1921, Dr. Douglas A. Thom of the Division of Mental Hygiene, State Department of Mental Diseases, Massachusetts, has been conducting habit clinics for children in Boston and in various parts of the State of Massachusetts. In his bulletin, *Habit Clinics for the Child of Preschool Age*, Dr. Thom writes of the growth of these clinics:

... Since November, 1921, when the first clinic was started with a staff consisting of only one physician, in attendance one-half day a week, to the present writing (August 15, 1923), a period of less than two years, six clinics have been organized in the State of Massachusetts—three under the Community Health Association of Boston and three under the department of mental diseases in the division of mental hygiene. Two more will be added to the latter group by November 1, 1923.*

In an article on "Habit Clinics in Massachusetts," Dr. Olive A. Cooper writes:

The Division of Mental Hygiene as a part of its preventive program has organized what are known as Habit Clinics for preschool children. These units aim to concern themselves chiefly with those children within the ages of two to eight years, who are manifesting any threatening or neurotic symptoms including such conditions as nail biting, temper tantrums, running away, lying, stealing, food capriciousness, enuresis, destructiveness and abnormal sex habits; in other words, they are those traits which one feels would tend to undermine the child's mental development or effect a thwarted personality later on in life and they also are accepted as habits which bear a relationship to the conditions of mental instability occurring in adult life.

An attempt has been made, in so far as has been possible, to locate these clinics geographically so that all sections of the State would receive a service. However, to date this has not been entirely practicable, since there are still sections not within reach of any of the clinic facilities. It is hoped that in time these vicinities will all be served. The following clinics are now being operated in Boston:

South Bay Union, 640 Harrison Avenue	Tuesday, A.M. 9:30
New England Hospital for Women and Children, Longwood Avenue	Thursday, A.M. 9:30
North End Health Unit, 41 North Margin St.	Thursday, P.M. 2:30
Boston Dispensary, Children's Medical, 25 Bennett Street	Friday, A.M. 9:30
Roxbury Crossing, 1049 Columbus Avenue	Friday, A.M. 9:30
West End Blossom Street Health Unit, 17 Blossom St.	Saturday, A.M. 9:30

There are also those in:

Springfield, 9 Market St.	Tuesday, P.M. 2:30
Lowell, Corporation Hospital	Wednesday, P.M. 2:30

* U.S. Department of Labor, Children's Bureau Publication No. 135 (1924), p. 59.

Lynn Hospital, Boston Street	Wednesday, P.M. 2:30
Lawrence, Lawrence General Hospital	Friday, P.M. 2:30
Reading, Reading High School	Thursday, A.M. 9:30
(once a month, first Thursday)	
Beverly, Beverly Health Unit	Thursday, A.M. 9:30
(once a month, second Thursday)	

Any child exhibiting one or more of the above mentioned traits, and coming within the specified age range is eligible for clinic service. The name and address of the child and also a description of his problem may be sent in to the Division of Mental Hygiene, Room 106, State House, and one of the workers will in turn make the first contact with the family and assign the child to the clinic which she feels he could reach most easily.

Every patient is given on his first visit, a psychological and a psychiatric examination; the first being given in an attempt to obtain an idea of the child's intellectual equipment, while the latter is an endeavor to ascertain why, if the child is normally equipped from an intellectual standpoint, he is showing the particular difficulty which he does. A social service picture of the situation is secured before the patient visits the clinic, and a physical examination is completed in order to rule out the presence of any physical factors as playing a part in the causation. This last is of importance and necessary before one is justified in advancing on the Habit Clinic basis.

The organization of these Habit Clinics, we feel, serves as a means for fulfilling the need for preventive work among children, which all admit is becoming increasingly apparent.⁴

Other State Habit Clinics. Of a number of other habit clinics under state supervision, Mary C. Jarrett writes:

Other mental-hygiene clinics for children under a variety of names, existing as independent units or as departments of general psychiatric clinics or medical clinics, are to be found throughout the country. In some of them the work is carried on along the same lines as the work of the special child-guidance clinic. The Institute for Juvenile Research in Chicago, an activity of the Illinois State Department of Welfare, has been a pioneer in this field. Its facilities provide for complete examination and intensive treatment of children from the standpoints of psychiatry, medicine, psychology, and social work. Another example of a mental-hygiene clinic for children under state auspices is the Bureau of Juvenile Research of the Ohio State Department of Public Welfare in Columbus. New Jersey has a state psychiatric clinic under the Department of Institutions which provides diagnostic service for the correctional institutions of the state, including the reform schools for boys and girls.⁵

Pennsylvania and Iowa have each developed a type of habit clinic for the benefit of children living in rural districts. Of these Miss Jarrett writes:

⁴ *The Commonwealth*, XII, 2 (April-May-June, 1925): 54-5.

⁵ *Mental Clinics: An Account of Their Development in the United States*, pp. 39-40.

The problem of mental-hygiene clinics for children in remote rural districts is being met in Pennsylvania in a unique way. The Bureau of Mental Health in the State Department of Welfare conducts about forty traveling clinics throughout the state. The staff of each clinic consists of a psychiatrist and a secretary. The psychiatrist is usually a member of the staff of a state or county hospital, or of the bureau itself, or occasionally a volunteer from private practice. The secretary is a resident of the community served, usually a social worker or a nurse. She arranges in advance, as far as possible, for the filling out of a social-history blank, a psychological and a physical examination, and the securing of a copy of the school record with a statement of the teacher's estimate of the child. Three field agents, who have had graduate training in psychology, serve as clinic secretaries in certain localities, where no one is available for the work, give the mental tests, and prepare the cases for examination by the psychiatrist. In one very remote district, the field agent goes to the town and gives mental tests whenever the Red Cross nurse has three children awaiting examination. If a psychiatric study of the children is indicated, they may be taken at the expense of the bureau to a center where one of the traveling clinics is held.

The most recent development of mental-hygiene clinic service for rural neighborhoods is the mobile clinic experiment that is being conducted by the Psychopathic Hospital of the State University of Iowa, and supported by the Rockefeller Foundation. The project also includes the investigation of certain problems in cerebral dominance suggested by the study of children referred because of special reading disabilities. The program is to be carried out by two groups of workers—a mobile unit and a laboratory unit. The latter will include medically trained research assistants in neuro-anatomy and cerebral physiology, a psychologist working under the National Research Council on similar problems in speech disorders, and an experimental teacher who will work directly with a group of these children.

The mobile unit will hold mental-hygiene clinics in selected communities throughout the state and is under the immediate direction of a psychiatrist assisted by a psychiatric social worker, a psychometrist, a secretary, and a student social worker. Communities will be chosen in which there is county-wide interest in the clinic and invitations from the local physicians, the courts, the schools, and the social workers. Whenever possible, the community will also be expected to contribute to the local expense of the clinic.

The clinic will remain a month or six weeks in one place and will examine children and adults by appointment. The physical-social-psychological-psychiatric aspects will be covered in the usual way—staff meetings held on all cases, reports and recommendations discussed with the referring agencies, and some plan for follow-up consultations worked out. Cases in need of more extended study will be referred to the psychopathic hospital and problems of interest from a research point of view to the laboratory unit. The director of the hospital is assisted by a psychiatric social worker in the field organization for the mobile unit, the correlation of the work of the two units, the getting out of reports, and so forth.

The unique features of this mobile mental-hygiene clinic are:

1. The field—a rural Mid-Western state with resources neither in psychiatry nor in social work, outside of one or two of the larger cities and the university center. This means that most of the ninety-nine counties will never be able to support a psychiatric clinic of their own, and a state service, therefore, seems indicated, although here the prejudice against “state medicine” will undoubtedly be encountered.

2. The organic relationship of the mobile clinic with the psychopathic hospital and with the university. This furnishes not only continuity to such a program and prestige with local physicians, but indispensable resources for diagnosis in doubtful cases where extensive laboratory tests and further observations are indicated, care for acute cases, and facilities for training and re-education in others. The relationship with the hospital and university also makes it possible to provide the clinic with extra help—clerical, psychological, social, psychiatric, as it is needed, and in turn to offer field work experience to students in sociology, child welfare, and educational psychology.

3. Supervision from the hospital. The director is actively directing the clinic program, and the social worker assisting him gives practically full time to matters of organization, personnel, and methods. It seems of value to have some one more or less detached from the work to criticize, give suggestions, and keep it well rounded out. Frequent conferences and staff meetings will be held at the hospital and in the field.

4. A schedule allowing frequent intervals at Iowa City to keep up with reports, and two months a year—July and December—planned for study and institutes at the hospital with a scientific unit.⁶

COUNTY HABIT CLINICS

Habit Clinics of Monmouth County, New Jersey. In 1923, Monmouth County, New Jersey, established habit clinics for children as a part of its preventive program. Concerning the clinics for children up to seven years of age, the Monmouth County Social Service Report gives the following information:

General Method. In these clinics as in the adolescent consultation centers, children who present problems other than those characteristic more or less of childhood, are not studied. The children were referred through the local public health nurse, often at the request of the mother. A clinical study is made of each child from the physical, mental, emotional and social viewpoints. As a result, recommendations are made to the mother or father (sometimes both) when she returns to the clinic from month to month. The physical examinations are made by the family physician or by the pediatrician in attendance at the Child Welfare Clinic, of which the Habit Clinic is a part.

The problems presented are in general connected with feeding, sleep, control of temper, health habits, thumb-sucking, work and play, association with other children and development of moral sense.⁷

⁶ *Mental Clinics*, pp. 34-6.

⁷ *Monmouth County Organization for Social Service Report, 1924-1925*, p. 41.

CITY HABIT CLINICS

Habit Clinics of Detroit, Michigan. In 1925 a habit clinic was established in the neurological division of the out-patient department of the Children's Hospital of Michigan, in Detroit, which is supported in part by the city and in part by the Detroit Community Fund. In the same year the Department of Health of the city opened a habit clinic for children in connection with its baby clinics.

Neighborhood Clinics. Of the small, city clinics serving a single neighborhood, Miss Jarrett writes as follows:

The small mental-hygiene clinic serving the residents of one neighborhood in a city is one of the most recent developments. In New York City, clinics of this sort are held in the Chelsea district by the Hudson Guild and in the East Harlem district under the auspices of the State Charities Aid Association.

At Greenwich House, the neighborhood center of the Greenwich district, there has recently been opened a mental-hygiene clinic with a complete staff, including a psychiatrist, a physician, a psychologist, and a psychiatric social worker. For special diagnostic tests patients are sent to nearby medical institutions.^a

HABIT CLINICS IN PRIVATE INSTITUTIONS

Mount Sinai Hospital Clinic. Among the first habit clinics in the United States was the one established by Dr. Ira S. Wile at Mount Sinai Hospital, New York City, in June, 1919. Miss Lucy M. Neary, social worker in the Children's Health Class of the Hospital, gives the following account of the clinic:

Dr. Ira S. Wile established a habit clinic under the name of "The Children's Health Clinic" in the Social Service Department of Mount Sinai Hospital, New York City, June, 1919. The clinic has run continuously since that time. The clinic admits children from two to sixteen years of age. In 1927 there were 366 patients admitted to the class, about one-fifth of whom were preschool children.^b

Yale Psycho-Clinic. The Yale Psycho-Clinic at New Haven is another habit clinic operated and supported by a private institution. Of this clinic, Miss Jarrett writes:

A clinic that deals with children of preschool age as well as school children in about equal numbers, the Yale Psycho-Clinic, has been carried on for a number of years in connection with the Yale Polyclinic, which makes the physical examination in its department of pediatrics. For the past few years, the emphasis of the work has been upon children of preschool age, including

^a *Mental Clinics*, p. 41.

^b In a letter to the author, dated January 24, 1928.

early infancy. . . . No provision is made for social work through the clinic. Two psychological examiners assist the psychiatrist.³⁰

The Merrill-Palmer Consultation Center. In 1924, the Merrill-Palmer School, a private institution in Detroit, opened a habit clinic for preschool children, which was called a Consultation Center. The first year's work of the Center is described as follows in the 1924 *Report* of the school:

One hundred and three children have been examined in the Center. Of these, thirty-one were referred by physicians, thirty-eight by social agencies, and thirty-five came just through an interest in having the children examined. . . . The children have presented a very interesting variety of problems. A few of them have been feeble-minded, but most of them have been normal children who were suffering from various types of habits that needed to be corrected. Sometimes the problem was one of eating, sometimes one of sleeping, sometimes of general disposition, and sometimes a problem of nervous habits of various sorts.

The children sent to us by social agencies come from two of the larger agencies who have young children to give out for adoption. They are the Michigan Children's Aid Society and the St. Vincent de Paul Society. We are examining for these two organizations most of the children under six years of age who are candidates for adoption. The agencies send us an account of the physical examination of the child and of the social record, and we make a mental examination and advise them as to how promising a risk the child is for adoption.

Many of the children who have come just out of interest are the children of unusually alert and intelligent parents who would like to have an estimate on the child's ability and advice as to the most valuable educational procedures.³¹

Habit Clinic of the Institute of Child Welfare Research. In the fall of 1924, the Institute of Child Welfare Research of Teachers College, Columbia University, established a habit clinic for preschool children.

The clinic is unique in that it serves not only as a center for assisting children of preschool age to adjust themselves to their environment, but also as a training center for students. Dr. Bess V. Cunningham, Supervisor of the Clinic, writes of it as follows:

The Educational Clinic of Teachers College was established in answer to the widespread demand for increased facilities for uniting interdepartment interests in the problems of young childhood and at the same time providing an extensive field of student endeavor in all phases of child guidance

³⁰ *Mental Clinics*, pp. 40-1.

³¹ *Merrill-Palmer School of Homemaking, Fifth Annual Report*, pp. 24-5.

The Clinic was first opened to any agency or individual who sought help in connection with a child problem which was not obviously medical in nature. The only age limitation stated was the upper limit of eighteen years. The actual range in ages was from two to eighteen.

The reasons given for referring the children to the Clinic varied all the way from definite problems, such as wrong grade placement in school, to such indeterminate accusations as "unruly" or "nervous." In the analysis of these difficulties of adjustment in the home and in the school almost the entire range of child problems seemed to be indicated and the possibilities of using the Clinic as a means of training students with many interests were thus demonstrated during the first year.

At the beginning of the second year, the scope of the Clinic was enlarged. A program of special research was inaugurated, facilities for student participation were greatly increased, and the responsibility for examination was placed more largely upon regularly appointed staff members. Those members of the original committee who were interested in making immediate use of the Clinic as a laboratory for their own students continued in active service throughout the second year.

This committee agreed that some measures should be taken by means of which routine clinical service could be extended to unselected normal children and study of the same children continued for a period of several years. To this end a policy of examination of one-year-old and three-year-old children was adopted. The children were so selected as to make the sampling as near normal as possible

It also seemed necessary to continue the original type of clinic cases, children who presented some problem of deviation. These children offered the best materials for student enterprise because difficulties were thrown into high relief. In this connection a need for a different type of clinic worker was discovered. In most instances the difficulty of the child could be traced to mistakes in the home

During the third and present year the Clinic is continuing the program as previously outlined with the addition of further student opportunities.¹³

The Commonwealth Fund Demonstration Clinic. The Commonwealth Fund, a private organization with headquarters in New York City, has carried on since 1922 an extensive demonstration program with habit clinics for children. The purpose of these demonstration clinics is described as follows in the October, 1926, *Progress Report* of the Fund:

This Division (Child Guidance Clinics) of the Commonwealth Fund Program is administered by the National Committee for Mental Hygiene through its Division on the Prevention of Delinquency and the Division administration staff has been primarily engaged in supervising demonstration child guidance clinics in cities which desire subsequently to establish under local auspices permanent child guidance clinics to serve the public schools, the

¹³ "The Educational Clinic as a Laboratory for Students in Training," *Teachers College Record*, XVIII, 8 (April, 1927): 814-8.

social agencies, the juvenile court, and parents in dealing with children presenting problems of adjustment to home, school, or community. The purpose of the demonstrations is not only to show the contribution psychiatric study can make to the treatment of behavior difficulties in children but to work out the functional relationships of a child guidance clinic to those other agencies in the community, medical, educational, and social, on whose coöperation the effectiveness of the clinic's work must largely depend.¹³

Following the demonstration by the Commonwealth Fund, permanent clinics have been established in St. Louis, Dallas, Minneapolis, St. Paul, Cleveland, Philadelphia, Los Angeles, Richmond, Baltimore, Milwaukee, and Pasadena.¹⁴

Of these permanent clinics, Miss Jarrett writes:

In some cities the permanent child-guidance clinics are supported by the Community Chest. This is the case in Dallas, Memphis, and Los Angeles. In St. Paul, the work is financed by an endowed philanthropic organization, The Wilder Charities. In Minneapolis the board of education has assumed full responsibility for the clinic. In Richmond, a psychiatric department of the Children's Memorial Clinic has been organized and is supported by local and state welfare departments. In St. Louis the city department of public welfare maintains the child-guidance clinic.

In New York City, the Bureau of Children's Guidance, which will be discontinued at the end of the five-year program, is to be succeeded by a permanent organization, the Institute for Child Guidance, financed by the Commonwealth Fund. The institute will have four main purposes: (1) to make possible further research and study in the field of mental hygiene for children, with special reference to the causes and methods of treatment of behavior problems; (2) to provide facilities for the training of psychiatrists and graduate psychologists in practical child-guidance work; (3) to provide field training in child guidance for students in psychiatric social work at the New York School of Social Work and the Smith College School of Social Work; and (4) to afford adequate clinical facilities for the thorough study and treatment of children who present problems in behavior and mental hygiene.¹⁵

¹³ *Commonwealth Fund Program for the Prevention of Delinquency, Progress Report*, October 1, 1926, p. 14.

¹⁴ C. E. Lakeman, Assistant Director of the Commonwealth Fund, in a letter to the author dated January 13, 1928.

¹⁵ *Mental Clinics*, p. 39.

CHAPTER III

AN ANALYSIS OF THE DATA CONCERNING THE PROBLEMS REFERRED TO THE HABIT CLINICS

METHOD OF ANALYZING DATA

The data secured from the seven habit clinics whose records form the basis for this study were analyzed to determine the following points:

1. The types of problems, either referred to or discovered by the clinics, and the frequency of their occurrence.
2. The distribution of the chronological ages and mental levels of the 225 cases (110 boys and 115 girls) by sex.
3. The following data concerning the parents or foster-parents of the problem children: (*a*) birthplace, (*b*) education, (*c*) religion, (*d*) occupation, and (*e*) home rating.
4. The types and frequency of occurrence of undesirable parental attitudes and practices in the parents of the problem children.
5. The number of children in the family of the problem child, the age position of the problem child in the family, and the number of problem children from "one child" families as compared with the number from "more than one child" families.
6. The age and mental level distributions for each of the fourteen problems of most frequent occurrence.
7. The coefficients of association of all possible pairs of the fourteen problems of most frequent occurrence.
8. Sex differences in the distribution of cases at the three mental levels for the fourteen problems of most frequent occurrence.
9. Points 2, 3 (except *c*), 4, 5, 6, 7, and 8, for the seven problems of most frequent occurrence: a further analysis.

ANALYSIS OF DATA

Of the following tables, Table 2 shows the types of problems referred to the clinics and the frequency of occurrence; Tables 3 and 4, the distribution of the chronological ages and mental levels,

respectively, of the boys and girls referred to the clinics; and Table 5, the percentages of boys and girls referred to the clinics, as compared with the percentages of boys and girls, of the same age, in the United States.

Tables 6 to 11 show the birthplaces, education, religion, and occupations of the parents or foster-parents of the problem children, and the rating of the home, and Table 12 shows the types and frequency of undesirable parental attitudes and practices in the parents or foster-parents of the children.

Table 13 shows the number of children in the family of the problem child; Table 14, the number of problem children from "one child" families as compared with the number from "more than one child" families; and Table 15, the age position of the problem child in the family.

Tables 16 to 45 show the age and mental level distributions for each of the fourteen problems of most frequent occurrence.

Table 46 shows the mean age of the children in relation to the problem for which they were referred to the clinic or which was discovered at the clinic for the fourteen problems of most frequent occurrence; and Table 47, the percentage of children in the "above average," "average," and "below average" mental level groups in relation to these problems, analyzed, in each case, according to sex.

Tables 48 to 53 show, for each sex and the sexes combined, the coefficients of association between all possible pairs of the fourteen problems of most frequent occurrence.

Table 54 shows sex differences in the distribution of the cases at the three mental levels ("above average," "average," and "below average") for the fourteen problems of most frequent occurrence.

Tables 55 to 62 present a further analysis of the seven problems of most frequent occurrence, with respect to data concerning the parents or foster-parents and families of the problem children.

A. THE TYPES AND DISTRIBUTION OF THE PROBLEMS

Children were referred to the clinics for from one to four problems, and from one (or none) to eleven additional problems were discovered by the clinics.¹ Of the 903 problems treated by the clinics, 249 were referred to them and 654 were discovered by them. These facts indicate that the parents either were not cognizant of these

¹ Children who needed medical care were treated by a physician either before or at the same time they were receiving treatment from the habit clinic.

TABLE 2

TYPES OF PROBLEMS REFERRED TO THE CLINICS AND THE FREQUENCY OF OCCURRENCE*

PROBLEM	NUMBER OF CASES		
	Boys	Girls	Total
Enuresis †	47	32	79
Need of surgical or medical care	37	40	77
Negativism ‡	34	43	77
Temper tantrums	38	28	66
Food §	28	35	63
Emotional dependence on adults	15	35	50
Poor nutrition	28	22	50
Speech ||	21	18	39
Restlessness ¶	17	13	30
Too much attention and interference from adults	13	17	30
Too little opportunity to play with children of the same age	13	16	29
Thumb- or finger-sucking	13	15	28
Masturbation	11	13	24
Fear	9	14	23
Too little outdoor play	6	9	15
Afternoon nap omitted	9	6	15
Need of toys and other educational materials..	9	6	15
Crying during sleep	4	11	15
Nail-biting	4	10	14
Poor motor control	5	9	14
Crying easily	2	12	14
Irregular habits	5	8	13
Sleep **	6	6	12
Jealousy	6	5	11
Destructiveness	8	3	11
Selfishness	5	5	10
Neurotic pains	2	7	9
Soiling	7	2	9
Personality changes	1	7	8
Need of conversation and stories	2	5	7
Irritability	4	2	6
Picking nose	3	2	5
Bottle used too long	2	2	4
Biting other children	2	1	3
Gritting teeth	2	1	3
Slapping adults	1	2	3
Teased by other children in the family	1	1	2
Nervous twitching of the eye or face	2	0	2
Running away	2	0	2

TABLE 2 (Continued)

PROBLEM	NUMBER OF CASES		
	Boys	Girls	Total
Indifference when reprimanded	1	1	2
Twisting own hair	0	2	2
Holding breath	1	0	1
Nervous cough	1	0	1
Showing off	1	0	1
Stealing	1	0	1
Eating plaster and ashes	1	0	1
Spitting	1	0	1
Biting own hand	0	1	1
Unreasonably indulged by other children	0	1	1
Lying	0	1	1
Day dreaming	0	1	1
Cruelty to animals	0	1	1
Excessive clothing	0	1	1
Total	431	472	903

* The data include problems discovered by the clinics, as well as those referred to them.

† The term "enuresis" designates problems connected with training for the control of urination during the day before two years of age and during the night before three years of age, as well as problems connected with the later psychological aspects of training.

‡ The term "negativism" designates contrary or stubborn behavior.

§ "Food" problems include lack of appetite, refusal of food, and regurgitation of food.

|| "Speech" problems include retardation in learning to talk, stuttering, and the use of "baby talk."

¶ The term "restlessness" designates problems of instability of attention and hyperactivity.

** The term "sleep" designates problems connected with going to sleep during the day or at night.

problems or did not wish to mention them. The 110 boys were treated for 431 problems, and the 115 girls for 472 problems. Fifty-three kinds of problems were treated by the clinics.

From Table 2, it will be seen that there are two distinct drops in the frequency of occurrence of the problems—the first, a drop from 50 to 39, between *poor nutrition*, the seventh problem in rank order, and *speech*; and the second, a drop from 23 to 15, between *fear*, the fourteenth problem in rank order, and *too little outdoor play*. Because of their apparent importance, it has seemed advisable to study these fourteen problems of most frequent occurrence more intensively than the others; and since the first seven problems have a frequency considerably higher than the second seven, it has seemed advisable to analyze them still further.

Table 3 shows that the age range for the fifty-three problems is between one and five years for both boys and girls. The mode for boys is 22, between 3 and 3½ years; for girls, 26, between 4 and 4½ years. For the total number of cases, the mode is 46, between 3 and 3½ years. The mean age for boys is 3.31 years; for girls, 3.44; and for the total number of cases, 3.37.

TABLE 3
AGE AND SEX DISTRIBUTION OF THE 225 CASES

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	2	2	4
1½-2	6	8	14
2 -2½	16	9	25
2½-3	21	14	35
3 -3½	22	24	46
3½-4	15	20	35
4 -4½	8	26	34
4½-5	20	12	32
Total	110	115	225
Mean	3.31	3.44	3.37
Standard Deviation	0.95	0.89	0.92

Table 4 shows that, for the total number of problems, a larger percentage of girls than boys were in the "above average" and "average" mental level groups. The greatest difference between the sexes in this respect is in the "below average" group, where the percentage of boys is 13.2 greater than the percentage of girls.

TABLE 4
MENTAL LEVEL DISTRIBUTION OF THE 225 CASES

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	28	34	62	25.5	29.6	27.5
Average	55	68	123	50.0	59.1	54.7
Below average ...	27	13	40	24.5	11.3	17.8*
Total	110	115	225	100.0	100.0	100.0

* The exclusion of feeble-minded children from the study, with no corresponding limit for the "above average" group, accounts, in part at least, for the fact that the proportion of cases "below average" is smaller than the proportion "above average."

TABLE 5

COMPARISON OF THE PERCENTAGE OF BOYS AND GIRLS BETWEEN ONE AND FIVE YEARS OF AGE IN THIS STUDY AND THE PERCENTAGE IN THE UNITED STATES

	PERCENTAGE		
	Boys	Girls	Total
In this Study *	48.9	51.1	100.0
In the United States †	50.7	49.3	100.0

* The data for this study were collected between 1923 and 1927.

† U. S. Census Report, 1920: III, 16, Table 3.

Although there are more boys than girls between the ages of one and five years in the United States, there were more girls than boys referred to the seven habit clinics whose records form the basis for this study. So far as the data are representative, this seems to indicate that girls of this age present more problems than boys, or that more is expected of the girls than of the boys.

B. DATA CONCERNING THE PARENTS AND FAMILIES OF THE PROBLEM CHILDREN

Table 8 shows that there were as many parents in the "illiterate to finishing the eight grade" group as in the three other groups combined.

The occupations of the fathers of the problem children represent almost every type, from that of rag picker and railroad lamp-lighter to that of Episcopal rector, lawyer, and college professor.

TABLE 6

BIRTHPLACES OF THE PARENTS OF THE PROBLEM CHILDREN

COUNTRY	FATHER	MOTHER	TOTAL	PERCENTAGE
United States	140	147	287	64
Russia	20	13	33	7
Italy	16	14	30	7
Canada	9	7	16	4
England	6	9	15	3
Austria	5	7	12	2
Ireland	5	5	10	2
Greece	4	5	9	2
Hungary	4	4	8	2
Syria	3	3	6	1
Poland	3	2	5	1
Scotland	2	1	3	1
Belgium	1	1	2	0

TABLE 6 (Continued)
BIRTHPLACE OF THE PARENTS OF THE PROBLEM CHILDREN

COUNTRY	FATHER	MOTHER	TOTAL	PERCENTAGE
Germany	1	1	2	0
Norway	1	1	2	0
Spain	0	2	2	0
Sweden	2	0	2	0
Bulgaria	1	0	1	0
Denmark	0	1	1	0
Holland	1	0	1	0
Lithuania	0	1	1	0
Rumania	0	1	1	0
Wales	1	0	1	0
Total	225	225	450	96 *

* Owing to the fact that one and two cases represent less than 1 per cent, the total percentage is 96 instead of 100.

TABLE 7
THE NUMBER OF PARENTS OF PROBLEM CHILDREN BORN IN THE UNITED STATES,
AS COMPARED WITH THE NUMBER BORN IN OTHER COUNTRIES

BIRTHPLACE	FATHER	MOTHER	TOTAL	PERCENTAGE
United States	140	147	287	64
Other Countries	85	78	163	36
Total	225	225	450	100

TABLE 8
EDUCATIONAL TRAINING OF THE PARENTS OF THE PROBLEM CHILDREN * †

EDUCATIONAL TRAINING	FATHER	MOTHER	TOTAL	PERCENTAGE
From illiterate to finishing the eighth grade ..	122	103	225	50
Attending or finishing high school	44	75	119	27
Attending or finishing college or postgraduate schools	49	37	86	19
No data	10	10	20	4
Total	225	225	450	100

* Thirty-nine, or 8 per cent, of the parents had also registered in special schools, including technical schools, business colleges, correspondence schools, kindergarten training schools, music schools, and nurse's training schools.

† Memoirs XV of the National Academy of Sciences (1921, page 758, Table 302) gives the following data concerning the schooling of United States Army officers and recruits: grades, 67 per cent; high school, 17 per cent; college and postgraduate, 15 per cent. The schooling of the fathers of the children in this study is as follows: grades, 54 per cent; high school, 20 per cent; college, 22 per cent; and unknown, 4 per cent.

TABLE 9
RELIGION OF THE PARENTS OF THE PROBLEM CHILDREN *

RELIGION	FATHER	MOTHER	TOTAL	PERCENTAGE
Protestant	94	96	190	42
Roman Catholic	74	73	147	33
Jewish	36	35	71	16
Greek Catholic	5	5	10	2
No preference, or no data given	16	16	32	7
Total	225	225	450	100

* For the entire United States, the *Statistical Abstract of the United States, 1928*, shows the following distribution of religious membership: Protestant, 32 per cent; Roman Catholic, 20 per cent; Jewish, 6 per cent; Greek Catholic, 0 per cent; and non-members, 42 per cent (pages 5 and 61). These data cannot be considered of any great worth, since they represent a combination of the data concerning "religious bodies, churches, and members by denominations" for the white population above thirteen years of age for the year 1926, and those concerning the age distribution of the white population fifteen years of age and above from the 1920 Census; but they are interesting as tending to show that the incidence of members of the various religious groups among the parents of the problem children is roughly coincident with the incidence of these groups in the general population, and, accordingly, that the religious group the parents belong to is of little significance in this connection.

TABLE 10
OCCUPATIONS OF THE FATHERS OF THE PROBLEM CHILDREN *

CLASS OF OCCUPATION †	NUMBER	PERCENTAGE
Unskilled	72	32
Semiskilled	38	17
Skilled	16	7
Retail dealers and owners of small stores	38	17
Executives and business managers	20	9
Professional	41	18
Total	225	100

* The data represent the occupations of the fathers at the time the social histories were taken at the clinics.

† After the Taussig Industrial Classification, described in *Genetic Studies of Genius*, by Lewis M. Terman, *et al.*, I, 64.

TABLE 11
RATING OF THE HOMES OF THE PROBLEM CHILDREN

HOME SCORE	NUMBER	PERCENTAGE
Superior	31	14
Good	70	31
Fair	74	33
Poor	50	22
Total	225	100

As shown in Table 10, the "unskilled" group is largest, with the "professional" group second, and the "semiskilled" and "retail dealers" groups very little smaller than the "professional" group. The "executives" group ranks next, with the "skilled" group smallest of the six.

Although the percentage of problems might be expected to increase in the order of decreasing Home Score, the data in Table 11

TABLE 12

TYPES AND FREQUENCY OF UNDESIRABLE PARENTAL ATTITUDES AND PRACTICES
IN THE PARENTS OF THE PROBLEM CHILDREN *

UNDESIRABLE ATTITUDE OR PRACTICE	NUMBER OF CASES
Disagreement of parents on discipline	28
Friction between parents	22
Nagging the child and comparing him unfavorably with other children	20
Lax and inconsistent discipline	18
Lack of sense of responsibility for training child	16
Tension between mother and child	15
Waiting on child too much	14
Bribing and deceiving child	12
Spanking child	12
Friction between child and grandparent	12
Failure to understand the child	12
Showing favoritism to other children or to problem child	10
Domineering attitude toward child	10
Threatening the child and failing to carry out the threat. .	7
Too many "bosses" for the child	7
Lack of cleanliness	6
Instability	6
Failure to coöperate with clinic	5
Worrying about the child	5
Excessively severe with child	5
Too indulgent with child	4
Failure to provide enough income	3
Not patient in answering questions	3
Language handicap	3
Discussing the child's problems in his presence	3
Forcing the child to read	2
Frightening the child to secure obedience	2
Jealous of the child	1
Despondency	1
Total	264

* Though the case history blanks used by the clinics did not provide for a statement of undesirable attitudes or behavior in the parents, these were mentioned in several of the case summaries.

do not, as a matter of fact, show this to be the case in the present study. Although, as expected, the smallest percentage of problems appears in the "superior" group, the next smallest percentage appears not in the "good" group, but in the "poor" group, and the largest percentage is not in the "poor" group, but in the "fair" group.

TABLE 13
NUMBER OF CHILDREN IN THE FAMILIES OF THE PROBLEM CHILDREN

NUMBER OF CHILDREN IN THE FAMILY	NUMBER OF CASES
1	80
2	78
3	34
4	18
5	7
6	4
7	2
8	1
9	1
Total	225

TABLE 14
COMPARISON OF THE NUMBER OF PROBLEM CHILDREN FROM "ONE CHILD"
FAMILIES AND THE NUMBER FROM "MORE THAN ONE CHILD" FAMILIES

	NUMBER	PERCENTAGE
"One child" family	80	35.6
"More than one child" family	145	64.4
Total	225	100.0

TABLE 15
AGE POSITION OF THE PROBLEM CHILD IN THE FAMILY *

AGE POSITION	NUMBER			PERCENTAGE		
	Boys	Girls	Total	Boys	Girls	Total
Only child	36	44	80	32.7	38.3	35.6
Younger or youngest child	45	33	78	40.9	28.7	34.7
Between older and younger children..	13	15	28	11.8	13.0	12.4
Older or oldest child	16	23	39	14.6	20.0	17.3
Total	110	115	225	100.0	100.0	100.0

* Two pairs of twins are included in this study; one pair were the oldest in the family and one pair the youngest.

Tables 13 and 15 show that there was a larger number of problem children from "one child" families than from families with any other number of children. It is to be noted, however, that Table 14 shows that there were fewer problem children from "one child" families than from "more than one child" families. A number of factors may explain the greater number of cases brought to the clinics from "one child" families than from families with any other number of children. It is possible that the parents with one child felt less able than those who had had experience in child training to deal with the problems presented by their children; or the parents with more than one child may have felt that they had less time to take their children to clinics. Since many of the families represented cannot be regarded as complete, it is probable that some of the children now listed as only children will later become the older or oldest children of their families. Again, the apparent tendency for the problems to decrease as the number of children in the family increases, as shown in Tables 13 and 15, may be explained by the decrease in the proportion of families having the larger numbers of children, rather than by the favorable effect of a larger number of children in the family.

C. ANALYSIS OF THE FOURTEEN PROBLEMS OF MOST FREQUENT OCCURRENCE

TABLE 16
AGE DISTRIBUTION OF THE 79 ENURESIS CASES

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	2	1	3
1½-2	3	2	5
2 -2½	9	6	15
2½-3	9	3	12
3 -3½	11	4	15
3½-4	5	5	10
4 -4½	3	9	12
4½-5	5	2	7
Total	47	32	79
Mean	3.06	3.31	3.16
Standard Deviation	0.92	0.97	0.94

TABLE 17
MENTAL LEVEL DISTRIBUTION OF THE 79 ENURESIS CASES

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	14	4	18	29.8	12.5	22.8
Average	22	21	43	46.8	65.6	54.4
Below average ...	11	7	18	23.4	21.9	22.8
Total	47	32	79	100.0	100.0	100.0

TABLE 18
DISTRIBUTION OF THE 79 ENURESIS CASES, ACCORDING TO DIURNAL AND NOCTURNAL OCCURRENCE

TIME OF OCCURRENCE	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Diurnal	3	1	4	6.4	3.1	5.0
Nocturnal	22	19	41	46.8	59.4	51.9
Diurnal and nocturnal	22	12	34	46.8	37.5	43.0
Total	47	32	79	100.0	100.0	100.0

TABLE 19
DISTRIBUTION OF THE REFERRED AND DISCOVERED CASES OF ENURESIS

TIME OF OCCURRENCE	NUMBER REFERRED			NUMBER DISCOVERED		
	Boys	Girls	Total	Boys	Girls	Total
Diurnal	2	1	3	1	0	1
Nocturnal	12	12	24	10	7	17
Diurnal and nocturnal	9	6	15	13	6	19
Total	23	19	42	24	13	37

TABLE 20

AGE DISTRIBUTION OF THE 77 CASES OF NEED OF SURGICAL OR MEDICAL CARE

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	1	1	2
1½-2	2	3	5
2 -2½	7	3	10
2½-3	7	4	11
3 -3½	6	8	14
3½-4	5	11	16
4 -4½	2	6	8
4½-5	7	4	11
Total	37	40	77
Mean	3.24	3.40	3.32
Standard Deviation	0.99	0.86	0.94

TABLE 21

MENTAL LEVEL DISTRIBUTION OF THE 77 CASES OF NEED OF SURGICAL OR MEDICAL CARE

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	11	14	25	29.7	35.0	32.5
Average	15	23	38	40.6	57.5	49.3
Below average ...	11	3	14	29.7	7.5	18.2
Total	37	40	77	100.0	100.0	100.0

TABLE 22
AGE DISTRIBUTION OF THE 77 CASES OF NEGATIVISM

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	0	0	0
1½-2	2	3	5
2 -2½	7	3	10
2½-3	6	5	11
3 -3½	5	9	14
3½-4	6	7	13
4 -4½	3	11	14
4½-5	5	5	10
Total	34	43	77
Mean	3.26	3.54	3.41
Standard Deviation	0.92	0.86	0.89

TABLE 23
MENTAL LEVEL DISTRIBUTION OF THE 77 CASES OF NEGATIVISM

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	11	13	24	32.4	30.2	31.2
Average	17	27	44	50.0	62.8	57.1
Below average ...	6	3	9	17.6	7.0	11.7
Total	34	43	77	100.0	100.0	100.0

TABLE 24
AGE DISTRIBUTION OF THE 66 TEMPER TANTRUM CASES

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	0	0	0
1½-2	0	2	2
2 -2½	5	2	7
2½-3	9	1	10
3 -3½	7	8	15
3½-4	8	5	13
4 -4½	1	6	7
4½-5	9	3	12
Total	39	27	66
Mean	3.48	3.53	3.50
Standard Deviation	0.85	0.88	0.81

TABLE 25
MENTAL LEVEL DISTRIBUTION OF THE 66 TEMPER TANTRUM CASES

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	5	5	10	12.8	18.5	15.1
Average	25	20	45	64.1	74.1	68.2
Below average ...	9	2	11	23.1	7.4	16.7
Total	39	27	66	100.0	100.0	100.0

TABLE 26
AGE DISTRIBUTION OF THE 63 FOOD PROBLEM CASES

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	0	0	0
1½-2	0	2	2
2 -2½	3	6	9
2½-3	9	5	14
3 -3½	7	4	11
3½-4	1	4	5
4 -4½	2	7	9
4½-5	8	5	13
Total	30	33	63
Mean	3.48	3.49	3.44
Standard Deviation	0.89	0.96	0.90

TABLE 27
MENTAL LEVEL DISTRIBUTION OF THE 63 FOOD PROBLEM CASES

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	8	6	14	26.7	18.2	22.2
Average	16	23	39	53.3	69.7	61.9
Below average ...	6	4	10	20.0	12.1	15.9
Total	30	33	63	100.0	100.0	100.0

TABLE 28

AGE DISTRIBUTION OF THE 50 CASES OF EMOTIONAL DEPENDENCE ON ADULTS

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	0	0	0
1½-2	1	4	5
2 -2½	2	2	4
2½-3	2	4	6
3 -3½	5	5	10
3½-4	2	5	7
4 -4½	0	10	10
4½-5	4	4	8
Total	16	34	50
Mean	3.41	3.50	3.47
Standard Deviation	0.93	0.94	0.94

TABLE 29

MENTAL LEVEL DISTRIBUTION OF THE 50 CASES OF EMOTIONAL DEPENDENCE ON ADULTS

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	7	8	15	43.7	23.5	30.0
Average	6	25	31	37.5	73.5	62.0
Below average ...	3	1	4	18.8	3.0	8.0
Total	16	34	50	100.0	100.0	100.0

TABLE 30
AGE DISTRIBUTION OF THE 50 CASES OF POOR NUTRITION

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	1	0	1
1½-2	2	2	4
2 -2½	3	3	6
2½-3	6	4	10
3 -3½	5	2	7
3½-4	5	2	7
4 -4½	2	4	6
4½-5	5	4	9
Total	29	21	50
Mean	3.28	3.39	3.33
Standard Deviation	0.97	1.01	0.99

TABLE 31
MENTAL LEVEL DISTRIBUTION OF THE 50 CASES OF POOR NUTRITION

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	11	11	22	38.0	52.4	44.0
Average	9	7	16	31.0	33.3	32.0
Below average ...	9	3	12	31.0	14.3	24.0
Total	29	21	50	100.0	100.0	100.0

TABLE 32
AGE DISTRIBUTION OF THE 39 SPEECH PROBLEM CASES

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	0	0	0
1½-2	0	1	1
2 -2½	6	2	8
2½-3	6	2	8
3 -3½	7	3	10
3½-4	2	5	7
4 -4½	2	2	4
4½-5	1	0	1
Total	24	15	39
Mean	3.06	3.25	3.13
Standard Deviation	0.67	0.73	0.71

TABLE 33
MENTAL LEVEL DISTRIBUTION OF THE 39 SPEECH PROBLEM CASES

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	3	0	3	12.5	0.0	7.7
Average	14	7	21	58.3	46.7	53.8
Below average ...	7	8	15	29.2	53.3	38.5
Total	24	15	39	100.0	100.0	100.0

TABLE 34
AGE DISTRIBUTION OF THE 30 CASES OF RESTLESSNESS

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	0	0	0
1½-2	1	1	2
2 -2½	1	3	4
2½-3	3	1	4
3 -3½	4	2	6
3½-4	3	1	4
4 -4½	3	2	5
4½-5	2	3	5
Total	17	13	30
Mean	3.46	3.40	3.43
Standard Deviation	0.82	1.04	0.93

TABLE 35
MENTAL LEVEL DISTRIBUTION OF THE 30 CASES OF RESTLESSNESS

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	5	6	11	29.4	46.2	36.7
Average	11	6	17	64.7	46.2	56.6
Below average ...	1	1	2	5.9	7.6	6.7
Total	17	13	30	100.0	100.0	100.0

TABLE 36

AGE DISTRIBUTION OF THE 30 CASES OF TOO MUCH ATTENTION FROM ADULTS

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	0	0	0
1½-2	0	3	3
2 -2½	2	1	3
2½-3	3	4	7
3 -3½	3	4	7
3½-4	3	2	5
4 -4½	2	0	2
4½-5	1	2	3
Total	14	16	30
Mean	3.36	3.03	3.18
Standard Deviation	0.74	0.90	0.84

TABLE 37

MENTAL LEVEL DISTRIBUTION OF THE 30 CASES OF TOO MUCH ATTENTION FROM ADULTS

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	8	7	15	57.1	43.8	50.0
Average	6	8	14	42.9	50.0	46.7
Below average ...	0	1	1	0.0	6.2	3.3
Total	14	16	30	100.0	100.0	100.0

TABLE 38

AGE DISTRIBUTION OF THE 29 CASES OF TOO LITTLE OPPORTUNITY TO PLAY
WITH CHILDREN OF THE SAME AGE

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	1	0	1
1½-2	1	1	2
2 -2½	0	1	1
2½-3	4	3	7
3 -3½	1	5	6
3½-4	1	2	3
4 -4½	0	2	2
4½-5	5	2	7
Total	13	16	29
Mean	3.44	3.37	3.41
Standard Deviation	1.19	0.83	1.00

TABLE 39

MENTAL LEVEL DISTRIBUTION OF THE 29 CASES OF TOO LITTLE OPPORTUNITY
TO PLAY WITH CHILDREN OF THE SAME AGE

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	4	9	13	30.8	56.3	44.8
Average	5	7	12	38.5	43.7	41.4
Below average ...	4	0	4	30.7	0.0	13.8
Total	13	16	29	100.0	100.0	100.0

TABLE 40

AGE DISTRIBUTION OF THE 28 CASES OF THUMB- OR FINGER-SUCKING

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	0	0	0
1½-2	1	1	2
2 -2½	3	2	5
2½-3	4	1	5
3 -3½	3	6	9
3½-4	1	1	2
4 -4½	0	4	4
4½-5	1	0	1
Total	13	15	28
Mean	2.50	3.22	3.11
Standard Deviation	0.74	0.76	0.78

TABLE 41

MENTAL LEVEL DISTRIBUTION OF THE 28 CASES OF THUMB- OR FINGER-SUCKING

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	5	5	10	38.5	33.3	35.7
Average	6	9	15	46.1	60.0	53.6
Below average ...	2	1	3	15.4	6.7	10.7
Total	13	15	28	100.0	100.0	100.0

TABLE 42
AGE DISTRIBUTION OF THE 24 CASES OF MASTURBATION

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	0	1	1
1½-2	0	1	1
2 -2½	1	0	1
2½-3	1	1	2
3 -3½	3	1	4
3½-4	3	2	5
4 -4½	1	6	7
4½-5	2	1	3
Total	11	13	24
Mean	3.01	3.60	3.60
Standard Deviation	0.74	1.03	0.91

TABLE 43
MENTAL LEVEL DISTRIBUTION OF THE 24 CASES OF MASTURBATION

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	3	3	6	27.3	23.1	25.0
Average	5	7	12	45.4	53.8	50.0
Below average ...	3	3	6	27.3	23.1	25.0
Total	11	13	24	100.0	100.0	100.0

TABLE 44
AGE DISTRIBUTION OF THE 23 CASES OF FEAR

YEARS OF AGE	NUMBER OF CASES		
	Boys	Girls	Total
1 -1½	0	0	0
1½-2	1	2	3
2 -2½	2	2	4
2½-3	2	3	5
3 -3½	2	0	2
3½-4	0	4	4
4 -4½	0	3	3
4½-5	2	0	2
Total	9	14	23
Mean	3.08	3.14	3.12
Standard Deviation	1.00	0.89	0.94

TABLE 45
MENTAL LEVEL DISTRIBUTION OF THE 23 CASES OF FEAR

MENTAL LEVEL	NUMBER OF CASES			PERCENTAGE OF CASES		
	Boys	Girls	Total	Boys	Girls	Total
Above average ...	4	2	6	44.5	14.3	26.1
Average	3	11	14	33.3	78.6	60.9
Below average ...	2	1	3	22.2	7.1	13.0
Total	9	14	23	100.0	100.0	100.0

TABLE 46

MEAN AGES OF THE CHILDREN TREATED AT THE CLINICS FOR THE FOURTEEN PROBLEMS OF MOST FREQUENT OCCURRENCE

PROBLEM	MEAN AGE			STANDARD DEVIATION		
	Boys	Girls	Total	Boys	Girls	Total
Enuresis	3.06	3.31	3.16	0.92	0.97	0.94
Need of surgical or medical care ...	3.24	3.40	3.32	0.99	0.86	0.94
Negativism	3.26	3.54	3.41	0.92	0.86	0.89
Temper tantrums	3.48	3.53	3.50	0.85	0.88	0.81
Food	3.48	3.40	3.44	0.89	0.96	0.90
Emotional dependence on adults	3.41	3.50	3.47	0.93	0.94	0.94
Poor nutrition	3.28	3.39	3.33	0.97	1.01	0.99
Speech	3.06	3.25	3.13	0.67	0.73	0.71
Restlessness	3.46	3.40	3.43	0.82	1.04	0.93
Too much attention and interference from adults	3.36	3.03	3.18	0.74	0.90	0.84
Too little opportunity to play with children of the same age	3.44	3.37	3.41	1.19	0.83	1.00
Thumb- or finger-sucking	2.90	3.22	3.11	0.74	0.76	0.78
Masturbation	3.61	3.60	3.60	0.74	1.03	0.91
Fear	3.08	3.14	3.12	1.00	0.89	0.94
All problems studied *.....	3.31	3.44	3.37	0.95	0.89	0.92

* See Table 2 for the complete list of problems referred to or discovered by the clinics.

Table 46 shows that the mean age of all the boys in the study was 3.31 years. The lowest mean age for the boys treated for the fourteen problems of most frequent occurrence was 2.9 years, for *thumb- or finger-sucking*, and the highest, 3.61 years, for *masturbation*. This shows that *thumb- or finger-sucking* tends to appear early and *masturbation* late in the age range of these fourteen problems. The difference between the highest and lowest mean ages for boys in these fourteen problems is less than the standard deviation (0.95) for all boys in the study.

The table shows also that the mean age of all the girls in the study was 3.44 years. The lowest mean age for the girls treated for the fourteen problems of most frequent occurrence was 3.03 years, for *too much attention from adults*, and the highest, 3.6, for *masturbation*. This shows that the problem arising from *too much attention from adults* is likely to appear early and *masturbation* late in the age range of these fourteen problems. The difference between the highest and lowest mean ages for girls in these fourteen

problems is less than the standard deviation (0.89) for all girls in the study.

The table shows further that the mean age for the total number of cases was 3.37, with the lowest mean age for those treated for the fourteen problems of most frequent occurrence 3.11 years, for *thumb- or finger-sucking*, and the highest, 3.6, for *masturbation*. This shows that, for the total number of cases, *thumb- or finger-sucking* tends to appear early and *masturbation* late in the age range. The difference between the highest and lowest mean ages for the total number of cases in these fourteen problems is less than the standard deviation (0.92) for the total number of cases for all problems studied.

Table 47 shows that, at the "above average" level, the percentage of girls is greater than the percentage of boys in 9 of the 14 problems, and the percentage of boys greater in 5 of the 14. At the "average" level, the percentage of girls is greater than the percentage of boys in 11 of the 14 problems, and the percentage of boys greater in 3 of the 14. At the "below average" level, this is reversed, with the percentage of boys greater in 11 of the 14 problems, and the percentage of girls greater in 3 of the 14.

Since in a number of cases several problems seemed to be associated with one another, it appeared advisable to measure this association statistically.

The Pearson r , usually employed in determining such correlations, could not be used in the present study, since the data given do not indicate numerically, or otherwise, the degree of intensity of the problem, but only its occurrence. The variables offer the problem in determining correlations that Rietz describes as arising "in connection with variables which do not admit of exact measurement or only admit of it with great labor, for example: color, temperaments, shapes."² The devices available for determining correlations with material of this kind include Yule's *coefficient of association*, the *tetrachoric correlation coefficient*,³ and the *coefficient of contingency*.⁴ Yule's coefficient of association was chosen for use

² H. L. Rietz (ed.), *Handbook of Mathematical Statistics*, p. 133.

³ The *tetrachoric correlation coefficient* requires so long and laborious a process of evaluation, even with the use of Pearson's *Tables for Statisticians and Biometricians*, that its use is practically prohibited with the present data. The probable error, furthermore, is much larger than with the Pearson r , and misinterpretation is thus likely to occur.

⁴ The *coefficient of contingency*, described by A. L. Bowley in his *Elements of Statistics*, although mathematically accurate, is difficult to interpret. Its appropriate use is with data of greater mathematical refinement than those of the present study.

TABLE 47
PERCENTAGE DISTRIBUTION OF THE MENTAL LEVELS OF THE CHILDREN TREATED AT THE CLINICS FOR THE FOURTEEN PROBLEMS OF MOST FREQUENT OCCURRENCE

PROBLEM	MENTAL LEVEL PERCENTAGE								
	Boys			Girls			Total		
	Above Average	Average	Below Average	Above Average	Average	Below Average	Above Average	Average	Below Average
Enuresis	29.8%	46.8%	23.4%	12.5%	65.6%	21.9%	22.8%	54.4%	22.8%
Need of surgical or medical care	29.7	40.6	29.7	35.0	57.5	7.5	32.5	49.3	18.2
Negativism	32.4	50.0	17.6	30.2	62.8	7.0	31.2	57.1	11.7
Temper tantrums	12.8	64.1	23.1	18.5	74.1	7.4	15.1	68.2	16.7
Food	26.7	53.3	20.0	18.2	69.7	12.1	22.2	61.9	15.9
Emotional dependence on adults	43.7	37.5	18.8	23.5	73.5	3.0	30.0	62.0	8.0
Poor nutrition	24.1	44.9	31.0	52.4	33.3	14.3	44.0	32.0	24.0
Speech	12.5	58.3	29.2	00.0	46.7	53.3	7.7	53.8	38.5
Restlessness	29.4	64.7	5.9	46.2	46.2	7.6	36.7	56.7	6.7
Too much attention and interference from adults	57.1	42.9	00.0	43.8	50.0	6.2	50.0	46.7	3.3
Too little opportunity to play with children of the same age	30.8	38.5	30.7	56.3	43.7	00.0	44.8	41.4	13.8
Thumb- or finger-sucking	38.5	46.1	15.4	33.3	60.0	6.7	35.7	53.6	10.7
Masturbation	27.3	45.4	27.3	23.1	53.8	23.1	25.0	50.0	25.0
Fear	44.5	33.3	22.2	14.3	78.6	7.1	26.1	60.0	13.0
All problems studied *	25.5%	55.0%	24.5%	29.6%	59.1%	11.3%	27.0%	54.7%	17.8%

* See Table 2 for the complete list of problems treated by the clinics.

TABLE 48
COEFFICIENTS OF ASSOCIATION FOR ALL POSSIBLE PAIRS OF THE FOURTEEN PROBLEMS OF MOST FREQUENT OCCURRENCE: Boys

PROBLEM	Enuresis	Need of surgical or medical care	Negativism	Temper tantrums	Food	Emotional dependence on adults	Poor nutrition	Speech	Restlessness	Too much attention from adults	Too little opportunity to play with children	Thumb- or finger-sucking	Masturbation	Fear
Enuresis	.....	-.23	-.13	-.02	-.10	.24	.10	.12	-.18	.25	.08	.08	-.15	.49
Need of surgical or medical care	-.23	.....	-.04	.19	.05	.16	.71	.24	.28	.12	.58	-.07	.07	-.01
Negativism	-.13	-.04	.....	.02	.43	.50	-.07	-.07	.51	.36	-.46	-.46	-.67	-.24
Temper tantrums	-.02	.19	.02	.....	.42	.43	-.18	.33	.02	.10	.43	-.31	.43	.44
Food	-.10	.05	.43	.42	.....	.22	.42	-.40	-.049	-.07	.34	.15	-.23	.21
Emotional dependence on adults	.24	.16	.50	.43	.22	.....	.04	-.24	1.00	.55	.55	.08	.19	.32
Poor nutrition	.10	.71	-.07	.18	.42	.04	.....	-.22	-.026	.34	.62	.15	-.23	.44
Speech	.12	.24	.07	.33	.40	-.024	.22	.....	-.06	.15	.15	.14	-.03	.10
Restlessness	.18	.28	.51	.02	.49	1.00	-.26	.06	.....	.28	.41	.41	.32	1.00
Too much attention from adults	.25	.12	.36	.10	.07	.55	.34	.15	.28	.....	.17	.26	.16	1.00
Too little opportunity to play with children	.08	.58	-.46	.43	.34	.55	.62	.15	.41	.17	.....	-.26	.28	.40
Thumb- or finger-sucking	.08	-.07	-.46	.31	.15	.08	.15	.14	.41	-.26	-.26	.....	.28	-.04
Masturbation	-.15	.07	.67	.43	.23	.19	-.23	.03	-.032	-.16	.28	.28	.....	.06
Fear	.49	-.01	-.24	.44	.21	.32	.44	.10	1.00	1.00	.40	-.04	.06	.....

with the present data because of its simplicity. With this method, using the formula,

$$Q = \frac{ad - bc}{ad + bc},$$

the coefficients of association vary from $+1$ to -1 . When the coefficient is 0, Yule speaks of the variables as "independent"; when it is from 0 to $+1$, he speaks of them as "tending toward complete association"; and when it is from 0 to -1 , he speaks of them as "tending toward complete dissociation."⁵ This interpretation and terminology are followed in the analysis of the correlations of the fourteen problems of most frequent occurrence.

Table 48 and Tables 49 and 50, which follow, show the coefficients of association for all possible pairs of the fourteen problems of most frequent occurrence, for boys, for girls, and for the total number of cases, respectively. Tables 51, 52, and 53 show the coefficients above $+0.3$ or -0.3 for the same data, and for the same three groups.

Table 51 shows that of the twenty-eight coefficients of association above $+0.3$ or -0.3 , for all possible pairs of the fourteen problems of most frequent occurrence, for boys, eight show a tendency toward complete association of the pairs of problems concerned, four a tendency toward complete dissociation, and three complete dissociation. Of the coefficients showing a tendency toward complete association, the highest is $+0.7$ in the case of *need of surgical or medical care* and of *poor nutrition*. Of the four coefficients showing a tendency toward dissociation, the highest is -0.7 , in the case of *negativism* and of *masturbation*. The coefficients show complete dissociation in three instances, as follows: *Emotional dependence on adults* and *restlessness*, *restlessness* and *fear*, and *too much adult attention* and *fear*. That is to say, in the 110 boys of the study, none of these pairs of problems occurred together in any case.

Table 52 shows that of the thirty-five coefficients of association above $+0.3$ or -0.3 for all possible pairs of the fourteen problems of most frequent occurrence, for girls, six show a tendency toward complete association (of which two pairs, *emotional dependence on adults* and *too little opportunity to play with children*, and *need of surgical or medical care* and *too little opportunity to play with children*, show a tendency toward complete association in the case of

⁵ G. U. Yule, *Introduction to the Theory of Statistics*, pp. 37-9.

TABLE 51

COEFFICIENTS OF ASSOCIATION ABOVE +0.3 OR -0.3* FOR ALL POSSIBLE PAIRS OF THE FOURTEEN PROBLEMS OF MOST FREQUENT OCCURRENCE: Boys

PROBLEMS	COEFFICIENT OF ASSOCIATION	NUMBER OF CASES OF EACH PROBLEM IN THE PAIR †	
Need of surgical or medical care and Poor nutrition	0.7	37	28
Need of surgical or medical care and Too little opportunity to play with children	0.6	37	13
Emotional dependence on adults and Too much attention from adults	0.6	15	13
Emotional dependence on adults and Too little opportunity to play with children	0.6	15	13
Poor nutrition and Too little opportunity to play with children	0.6	28	13
Enuresis and Fear	0.5	47	9
Negativism and Emotional dependence on adults	0.5	34	15
Negativism and Restlessness	0.5	34	17
Negativism and Too much attention from adults	0.4	34	13
Temper tantrums and Food	0.4	38	28
Temper tantrums and Emotional dependence on adults	0.4	38	15
Temper tantrums and Too little opportunity to play with children	0.4	38	13
Temper tantrums and Masturbation	0.4	38	11
Temper tantrums and Fear	0.4	38	9
Food and Poor nutrition	0.4	28	28
Poor nutrition and Fear	0.4	28	9
Too little opportunity to play with children and Fear	0.4	13	9
Negativism and Food	-0.4	34	28
Food and Speech	-0.4	28	21
Restlessness and Too little opportunity to play with children	-0.4	17	13
Restlessness and Thumb- or finger-sucking	-0.4	17	13
Negativism and Too little opportunity to play with children	-0.5	34	13
Negativism and Thumb- or finger-sucking	-0.5	34	13
Food and Restlessness	-0.5	28	17
Negativism and Masturbation	-0.7	34	11
Emotional dependence on adults and Restlessness	-1.0	15	17
Restlessness and Fear	-1.0	17	9
Too much attention from adults and Fear	-1.0	13	9

* Although the coefficients below +0.4 or -0.4 may indicate trends, the coefficients above +0.4 or -0.4 are more reliable (see Yule's "On the Association of Attributes," *Philosophic Transactions of the Royal Society*, Series A, Vol. 194, p. 276). Coefficients of +0.5 and -0.5 and above, are the only ones considered in the analysis. When the coefficients, as shown in Tables 48, 49, and 50, have a figure of more than 5 in the second place after the decimal, the first place after the decimal is counted one point higher for the coefficients shown in Tables 51, 52, and 53.

† The number of cases is stated in the order in which the problems are stated within the pairs, i.e., in the first pair there were thirty-seven cases of *need of surgical or medical care*, and twenty-eight cases of *poor nutrition*.

TABLE 52

COEFFICIENTS OF ASSOCIATION ABOVE +0.3 OR -0.3 FOR ALL POSSIBLE PAIRS OF THE FOURTEEN PROBLEMS OF MOST FREQUENT OCCURRENCE: *Girls**

PROBLEMS	COEFFICIENT OF ASSOCIATION	NUMBER OF CASES OF EACH PROBLEM IN THE PAIR	
Temper tantrums and Fear	0.6	28	14
Restlessness and Thumb- or finger-sucking....	0.6	13	15
Need of surgical or medical care and Too little opportunity to play with children	0.5	40	16
Negativism and Too much attention from adults	0.5	43	17
Emotional dependence on adults and Too little opportunity to play with children	0.5	35	16
Restlessness and Masturbation	0.5	13	13
Negativism and Fear	0.4	43	14
Temper tantrums and Restlessness	0.4	28	13
Poor nutrition and Too little opportunity to play with children	0.4	22	16
Poor nutrition and Restlessness	0.4	22	13
Too much attention from adults and Too little opportunity to play with children	0.4	17	16
Enuresis and Masturbation	-0.4	32	13
Negativism and Masturbation	-0.4	43	13
Temper tantrums and Poor nutrition	-0.4	28	22
Food and Emotional dependence on adults	-0.4	35	35
Too little opportunity to play with children and Thumb- or finger-sucking	-0.4	16	15
Too little opportunity to play with children and Masturbation	-0.4	16	13
Thumb- or finger-sucking and Fear	-0.4	15	14
Need of surgical or medical care and Temper tantrums	-0.4	28	32
Enuresis and Too much attention from adults ..	-0.5	32	17
Need of surgical or medical care and Thumb- or finger-sucking	-0.5	40	15
Speech and Too much attention from adults ...	-0.5	18	17
Speech and Too little opportunity to play with children	-0.5	18	16
Poor nutrition and Masturbation	-0.5	13	22
Food and Speech	-0.6	35	18
Emotional dependence on adults and Speech ...	-0.6	35	18
Enuresis and Poor nutrition	-0.7	32	22
Enuresis and Too little opportunity to play with children	-1.0	32	16
Temper tantrums and Too little opportunity to play with children	-1.0	28	16

PROBLEMS	COEFFICIENT OF ASSOCIATION	NUMBER OF CASES OF EACH PROBLEM IN THE PAIR	
Food and Too little opportunity to play with children	-1.0	35	16
Speech and Restlessness	-1.0	18	13
Speech and Thumb- or finger-sucking	-1.0	18	15
Restless and Too much attention from adults ..	-1.0	13	17
Too much attention from adults and Masturbation	-1.0	17	13
Masturbation and Fear	-1.0	13	14

* See notes to Table 51.

boys also); eight coefficients show a tendency toward complete dissociation; and eight show complete dissociation of the problems concerned. Of the six coefficients showing a tendency toward complete association, the highest is $+0.6$ in the cases of *temper tantrums* and *fear*, and *restlessness* and *thumb- or finger-sucking*. Of the eight coefficients showing a tendency toward complete dissociation, the highest is -0.7 , in the case of *enuresis* and *poor nutrition*. The coefficients show complete dissociation in eight instances, as follows: *Enuresis* and *too little opportunity to play with children*; *temper tantrums* and *too little opportunity to play with children*; *food* and *too little opportunity to play with children*; *speech* and *restlessness*; *speech* and *thumb- or finger-sucking*; *restlessness* and *too much attention from adults*; *too much attention from adults* and *masturbation*; and *masturbation* and *fear*. That is to say, in the 115 girls of the study, none of these pairs of problems occurred together in any case.

It is interesting to note that the pairs of problems showing complete dissociation for girls do not in any case show complete dissociation for boys; further, that the coefficients for the corresponding pairs of problems for boys are not more than -0.4 in any case.

These data indicate that the problems are less likely to appear in combination with one another in the case of girls than in the case of boys.

For the total number of cases, without regard to sex, the coefficients of association for all possible pairs of the fourteen problems of most frequent occurrence show "independence" in one instance—that of *masturbation* and *thumb- or finger-sucking*, where the coefficient is 0.0 . When the sexes are considered separately, this coefficient is $+0.28$ for boys and -0.31 for girls.

TABLE 53

COEFFICIENTS OF ASSOCIATION ABOVE $+0.3$ OR -0.3 FOR ALL POSSIBLE PAIRS OF THE FOURTEEN PROBLEMS OF MOST FREQUENT OCCURRENCE:

*Total Number of Cases**

PROBLEMS	COEFFICIENT OF ASSOCIATION	NUMBER OF CASES OF EACH PROBLEM IN THE PAIR	
Need of surgical or medical care and Poor nutrition	0.5	77	50
Need of surgical or medical care and Too little opportunity to play with children	0.5	77	29
Temper tantrums and Fear	0.5	66	23
Emotional dependence on adults and Too little opportunity to play with children	0.5	50	29
Poor nutrition and Too little opportunity to play with children	0.5	50	29
Negativism and Restlessness	0.4	77	30
Negativism and Too much attention from adults	0.4	77	30
Too little opportunity to play with children and Fear	0.4	29	23
Enuresis and Too little opportunity to play with children	-0.4	79	29
Negativism and Thumb- or finger-sucking	-0.4	77	28
Food and Restlessness	-0.4	63	30
Poor nutrition and Masturbation	-0.4	50	24
Too little opportunity to play and Thumb- or finger-sucking	-0.4	29	28
Negativism and Masturbation	-0.5	77	24
Food and Speech	-0.5	63	39
Emotional dependence on adults and Speech ...	-0.5	50	39
Emotional dependence on adults and Restlessness	-0.5	50	30
Masturbation and Fear	-0.5	24	23
Too much attention from adults and Masturbation	-0.6	30	24

* See notes to Table 51.

Table 53 shows that of the nineteen coefficients of association above $+0.3$ or -0.3 , for the total number of cases, five show a tendency toward complete association. Of these, four, in the cases of *need of surgical or medical care and poor nutrition*; *need of surgical or medical care and too little opportunity to play with children*, *emotional dependence on adults and too little opportunity to play with children*, and *poor nutrition and too little opportunity to play with children*, show a tendency toward complete association for boys considered separately. Three, in the cases of *temper tantrums*

and fear; emotional dependence on adults and too little opportunity to play with children; need of surgical or medical care and too little opportunity to play with children, show a tendency toward complete association for girls considered separately. Two, in the cases of emotional dependence on adults and too little opportunity to play with children, and need of surgical or medical care and too little opportunity to play with children, show a tendency toward complete association for both boys and girls considered separately and together. These data indicate that there may be a sex difference in the association of some of the pairs of problems, and none in others.

Six coefficients show a tendency toward complete dissociation. Of these, two, in the cases of *negativism* and *masturbation*, and *emotional dependence on adults* and *restlessness*, show a tendency toward complete dissociation for the boys considered separately; and four, in the cases of *food and speech*, *emotional dependence on adults and speech*, *masturbation and fear*, and *too much attention from adults and masturbation*, show a tendency toward complete dissociation for girls considered separately. Of the coefficients showing a tendency toward complete dissociation, the highest is — 0.6, in the case of *too much attention from adults and masturbation*. For boys considered separately, this coefficient is — 0.2, and for girls considered separately, — 1.00. The data indicate that there are sex differences in the dissociation of the pairs of problems.

The fact that the coefficients show less tendency to vary for the total number of cases, without regard to sex, than for boys and girls considered separately, indicates either that there are sex differences in the association of problems, or merely that data involving the larger number of cases are more reliable.

According to Chaddock, the chances are "high" that values falling more than 2σ above or below the computed value, and "favorable" that values falling more than 1σ above or below the computed value, indicate significant differences and cannot be attributed to errors of sampling alone. That, on the other hand, values varying less than $\pm 1\sigma$ from the computed value are probably to be explained by errors of sampling.^a

According to this classification, Table 54 shows that the chances are "high" that the difference between the sexes, in six cases, is not to be attributed to errors of sampling alone. Two of these cases fall in each of the three mental level groups. In the "above average"

^a R. E. Chaddock, *Principles and Methods of Statistics*, p. 241.

TABLE 54

DIFFERENCE BETWEEN PERCENTAGES OF BOYS AND GIRLS AT THE THREE MENTAL LEVELS, EXPRESSED IN STANDARD UNITS,* FOR THE FOURTEEN PROBLEMS OF MOST FREQUENT OCCURRENCE

PROBLEM	Difference of the Per Cent Sigma of the Difference of Per Cent †		
	MENTAL LEVEL		
	Above Average	Average	Below Average
Enuresis	1.9 σ	-1.7 σ	0.2 σ
Need of surgical or medical care	0.5	-1.5	2.6
Negativism	-0.2	-1.1	1.4
Temper tantrums	0.6	-0.9	1.9
Food	0.8	-1.4	0.8
Emotional dependence on adults	1.4	-2.5	1.5
Poor nutrition	2.1	0.8	1.5
Speech	1.8	0.7	-1.5
Restlessness	-0.9	1.0	-0.2
Too much attention from adults	0.7	-0.4	-1.0
Too little opportunity to play with children	-1.4	-0.3	2.4
Thumb- or finger-sucking	0.3	-0.7	0.7
Masturbation	0.2	-0.5	0.2
Fear	2.8	-2.4	1.0
All problems studied	-0.7 σ	-1.4 σ	2.6 σ

* G. U. Yule, *Introduction to the Theory of Statistics*, p. 257.

† The difference between the percentages is divided by the sigma of the difference of the percentages, in order to express the difference in standard units. The percentage of girls was subtracted from the percentage of boys; the plus sign, accordingly, indicates that the percentage of boys was greater than the percentage of girls, and the minus sign that it was less. Expressing the difference in standard units permits the use of the Table of Normal Probability Curve to determine the probabilities of the differences arising from errors of sampling alone.

mental level group, there is a sex difference of 2.1 σ for *poor nutrition* and 2.8 σ for *fear*. With *fear*, the chances are 191.3 to 1, and with *poor nutrition*, 26.9 to 1, that a similar sample would show a similar difference.⁷

In the "average" mental level group, there is a sex difference of -2.5 σ for *emotional dependence on adults* and -2.4 σ for *fear*. With *emotional dependence on adults*, the chances are 79.6 to 1, and with *fear*, 60 to 1, that a similar sample would show a similar difference.

In the "below average" mental level group, there is a sex differ-

⁷ H. O. Rugg, *Statistical Methods Applied to Education*, p. 389.

ence of 2.6 σ for *need of surgical or medical care* and 2.4 σ for *too little opportunity to play with children*. With *need of surgical or medical care*, the chances are 105.4 to 1, and with *too little opportunity to play with children*, 60 to 1, that a similar sample would show a similar difference.

In sixteen cases, the chances are "favorable" that the difference between the sexes is not to be attributed to errors of sampling alone. The chances vary from 2 to 1 for 1 σ , to 16.4 to 1 for 1.9 σ , that similar samples would show similar differences. Of these sixteen cases, four—*enuresis*, *emotional dependence on adults*, *speech*, and *too little opportunity to play with children*—fall in the "above average" mental level group; five—*enuresis*, *need of surgical or medical care*, *negativism*, *food*, and *restlessness*—fall in the "average" mental level group; and seven—*negativism*, *temper tantrums*, *emotional dependence on adults*, *poor nutrition*, *speech*, *too much attention from adults*, and *fear*—fall in the "below average" mental level group.

These data indicate that the chances are "favorable" that there is less difference between the sexes in the "above average" mental level group than in either of the others, and that there is less difference in the "average" group than in the "below average" group.

The data for all problems studied show a similar tendency, with a difference of -0.7σ in the "above average" group; -1.4σ in the "average" group; and 2.6 σ in the "below average" group.

In twenty-one cases out of forty-two, the difference between the sexes is less than 1 σ , and is probably to be explained by errors of sampling.

Of the fourteen problems, twelve show a difference between the sexes of more than $\pm 1\sigma$ at one or more of the three mental levels. Two problems, *thumb- or finger-sucking* and *masturbation*, do not show a difference between the sexes as large as $\pm 1\sigma$, at any of the three mental levels, which indicates that there is little or no sex difference in the occurrence of these problems.

Children with Nursemaids. A note on the problems of the children who had nursemaids may be of interest. Physicians, as well as psychologists, regard the nursemaid as an important influence in the rearing of small children.⁸ Fifteen of the 225 children of the present study had nursemaids. One child had had five nursemaids

⁸ See *Safeguarding Children's Nerves*, by J. J. Walsh and J. A. Foote, pages 99-100, and "Your Responsibility as Parents," by F. H. Allen, *Hospital Social Service*, XVII, 1 (January, 1928): 62-7.

during a period of twenty months. Among these children, there were fourteen cases of *enuresis*, eight cases of *negativism*, five of *temper tantrums*, three of *emotional dependence on adults*, one of *food problems*, one of *poor nutrition*, and one of *need of surgical or medical care*. The number studied is, of course, too small to warrant any general conclusions. So far as one can judge from the small number of cases, however, the data seem to indicate that children who have nursemaids present a larger proportion of emotional problems than the children in general, and that they present a smaller proportion of such physical problems as the *need of surgical or medical care* and *poor nutrition*.

Foster-Children. Sixteen of the 225 children were foster-children. Among these children, there were seven cases of *need of surgical or medical care*, seven cases of *negativism* (as compared with eight among the children who had nursemaids), three of *poor nutrition*, two of *temper tantrums*, one of *emotional dependence on adults*, and one of *enuresis*. As in the case of the children who had nursemaids, the number of foster-children studied is too small to warrant any general conclusions from the data. It is interesting to note, however, that seven of the sixteen foster-children needed surgical or medical care, as compared with one of the fifteen children who had nursemaids. The foster-children, however, presented but one case of *enuresis*, as compared with fourteen cases among the children who had nursemaids.

D. FURTHER ANALYSIS OF THE SEVEN PROBLEMS OF MOST FREQUENT OCCURRENCE

Table 55 shows irregularity in the percentages in both the children of American- and foreign-born parentage, for all seven problems; that is, no percentage corresponds with the expected. This irregularity varies from 12 below the expected (64) for *temper tantrums* and *food*, for the children of American-born parentage, to 12 above the expected (36) for *temper tantrums* and *food*, for the children of foreign-born parentage. For all seven problems combined, the variation is from 8 below the expected for the children of American-born parentage, to 8 above the expected for the children of foreign-born parentage. These data indicate that, in relation to these seven problems, the frequency of occurrence is less than the expected for the children of American-born parentage and greater than the expected for children of foreign-born parentage.

TABLE 55

PERCENTAGE OF CHILDREN OF AMERICAN-BORN PARENTAGE AS COMPARED WITH THE PERCENTAGE OF CHILDREN OF FOREIGN-BORN PARENTAGE, IN RELATION TO EACH OF THE SEVEN PROBLEMS OF MOST FREQUENT OCCURRENCE *

PROBLEM	PERCENTAGE OF CHILDREN OF AMERICAN-BORN PARENTAGE	PERCENTAGE OF CHILDREN OF FOREIGN-BORN PARENTAGE
Enuresis	67	33
Need of surgical or medical care	66	34
Negativism	68	32
Temper tantrums	52	48
Food	52	48
Emotional dependence on adults	66	34
Poor nutrition	69	31
All problems studied	64	36

* Since the data of this table and those following are expressed in terms of percentage, it is possible to compare the percentage representing the relation of a specific problem to the matter under consideration (here, for instance, the percentage who had American-born parents as compared with those who had foreign-born parents), with the percentage representing the relation of all problems studied to the matter under consideration, to determine whether the percentage is above, at, or below the expected, e.g., since the percentage of children of American-born parentage having *temper tantrums*, 52, is twelve less than the percentage representing the frequency of occurrence of all problems studied for children of American-born parentage, 64, we can say that the frequency of occurrence of *temper tantrums* for children of American-born parentage is 12 below the expected percentage.

Table 56 shows that, in relation to the frequency of occurrence of the seven problems, the percentages of children of parents born in the various foreign countries differ from one another as well as from the percentage of children of American-born parentage.

The three groups of foreign-born parentage showing the largest percentages—Russia, Italy, and 14 other countries, each with a percentage of 7—all show irregularity in the percentages representing the frequency of occurrence of the seven different problems. In the group of Russian-born parentage, this variation totals 8 above the expected; in the group of Italian-born parentage, 11 above the expected; and in the group of parents born in one of 14 other countries, 12 below the expected.

Table 57 shows that, in relation to the educational training of the parents, the percentages of children presenting each of the seven problems are irregular in the greater number of cases. This irregularity varies from 10 below the expected percentage (27) in the

TABLE 56

PERCENTAGE OF CHILDREN OF AMERICAN-BORN PARENTAGE AS COMPARED WITH THE PERCENTAGES OF CHILDREN OF PARENTS BORN IN CERTAIN OTHER COUNTRIES, IN RELATION TO EACH OF THE SEVEN PROBLEMS OF MOST FREQUENT OCCURRENCE

PROBLEM	PERCENTAGE OF CHILDREN IN RELATION TO BIRTHPLACE OF PARENTS									
	United States	Russia	Italy	Canada	England	Austria	Ireland	Greece	Hungary	One of 14 Other Countries
Enuresis	67	8	8	3	3	1	1	4	0	5
Need of surgical or medical care	66	4	5	5	4	4	0	0	4	8
Negativism	68	8	6	1	0	5	5	0	1	6
Temper tantrums	52	11	11	2	4	4	5	1	4	6
Food	52	13	9	8	2	3	3	2	2	6
Emotional dependence on adults	66	8	16	2	0	2	4	0	0	2
Poor nutrition	69	5	5	1	7	5	1	0	3	4
All problems studied	64	7	7	4	3	2	2	2	2	7

* These countries are Belgium, Bulgaria, Denmark, Germany, Holland, Lithuania, Norway, Poland, Rumania, Scotland, Spain, Syria, Sweden, and Wales.

TABLE 57

PERCENTAGE OF CHILDREN PRESENTING EACH OF THE SEVEN PROBLEMS OF MOST FREQUENT OCCURRENCE, IN RELATION TO THE EDUCATIONAL TRAINING OF THE PARENTS

PROBLEM	EDUCATIONAL TRAINING OF THE PARENTS			
	From illiterate to finishing the eighth grade	Attending or finishing high school	Attending or finishing college or postgraduate schools	No data
Enuresis	54	20	20	6
Need of surgical or medical care	46	30	19	5
Negativism	42	31	25	2
Temper tantrums	60	17	18	5
Food	51	25	16	8
Emotional dependence on adults	49	27	20	4
Poor nutrition	53	32	13	2
All problems studied	50	27	19	4

case of *temper tantrums* in the "high school" group, to 10 above the expected (60) for *temper tantrums* in the "elementary school" group. For all seven problems combined, the variation is 5 above the expected percentage for the "elementary school" group; 7 below for the "high school" group; 2 below for the "college and postgraduate" group; and 4 above for the "no data" group. These data indicate that, in relation to these seven problems, the frequency of occurrence is least in the "high school" group and greatest in the "elementary school" group.

Table 58 shows that, in relation to the occupational level of the fathers, the percentages of children presenting each of the seven problems are irregular in the greater number of cases. This irregularity varies from 14 below the expected percentage (32) for *poor*

TABLE 58

PERCENTAGE OF CHILDREN PRESENTING EACH OF THE SEVEN PROBLEMS OF MOST FREQUENT OCCURRENCE, IN RELATION TO THE OCCUPATIONAL LEVEL OF THE FATHERS

PROBLEM	OCCUPATIONAL LEVEL OF THE FATHER					
	Unskilled	Semiskilled	Skilled	Retail Dealers	Executives	Professional
Enuresis	42	14	9	12	5	18
Need of surgical or medical care	27	16	10	18	19	20
Negativism	23	15	8	21	12	21
Temper tantrums	38	18	4	17	6	17
Food	30	21	11	19	5	14
Emotional dependence on adults	26	24	4	18	8	20
Poor nutrition	18	26	2	28	14	12
All problems studied	32	17	7	17	9	18

nutrition in the "unskilled" group to 10 above the expected percentage (9) for *need of surgical or medical care* in the "executives" group. For all seven problems combined, the variation is 20 below the expected percentage for the "unskilled" group; 15 above for the "semiskilled" group; 1 below for the "skilled" group; 14 above for the "retail dealers" group; 6 above for the "executives" group; and 4 below for the "professional" group.

Table 59 shows that, in relation to the rating of the homes of the children, the percentages of children presenting each of the seven problems are irregular in the greater number of cases. The irregularity varies from 8 below the expected percentage (14) for *temper tantrums* in the "superior" homes group to 10 above for *temper*

TABLE 59

PERCENTAGE OF CHILDREN PRESENTING EACH OF THE SEVEN PROBLEMS OF MOST FREQUENT OCCURRENCE, IN RELATION TO THE RATING OF THE HOME

PROBLEM	RATING OF THE HOME			
	Poor	Fair	Good	Superior
Enuresis	25	39	27	9
Need of surgical or medical care	19	34	31	16
Negativism	18	34	38	10
Temper tantrums	32	36	26	6
Food	22	40	29	9
Emotional dependence on adults	16	36	28	20
Poor nutrition	18	36	32	14
All problems studied	22	33	31	14

tantrums in the "poor" homes group. For all seven problems combined, the variation is 4 below the expected percentage for the "poor" homes group; 24 above for the "fair" homes group; 6 below for the "good" homes group; and 14 below for the "superior" homes group. These data indicate that, in relation to these seven problems, the frequency of occurrence is least in the "superior" homes group and greatest in the "fair" homes group.

Table 60 shows that, in relation to undesirable parental attitudes and practices, the percentages of children presenting each of the seven problems are irregular in the greater number of cases. This irregularity varies from 6 below the expected percentage (7) for *food*, with children having parents who are listed as "nagging the child and comparing him unfavorably with other children," to 8 above the expected percentage (10) for *temper tantrums*, with children whose parents "disagree on discipline." For all seven problems combined, the variation is 18 above the expected percentage for "disagreement on discipline"; 9 below for "friction between parents"; 13 above for "lax and inconsistent discipline"; 3 above for "nagging and comparing the child unfavorably with others"; 8 below for "tension between mother and child"; 1 above for "lack of sense of

responsibility for training the child" and for "waiting on child too much"; 8 above for "bribing and deceiving child"; and 15 below for "domineering attitude toward child." These data indicate that "disagreement on discipline" is the most serious of the undesirable parental practices listed, and a domineering attitude toward the child the least serious.

TABLE 60

PERCENTAGE OF CHILDREN PRESENTING EACH OF THE SEVEN PROBLEMS OF MOST FREQUENT OCCURRENCE, IN RELATION TO THE NINE MOST COMMON UNDESIRABLE PARENTAL ATTITUDES AND PRACTICES IN THE PARENTS

PROBLEM	UNDESIRABLE ATTITUDE OR PRACTICE *								
	Disagreement on discipline	Friction between parents	Lax and inconsistent discipline	Nagging: comparing child unfavorably with others	Tension between mother and child	Lack of sense of responsibility for training child	Waiting on child too much	Bribing and deceiving child	Domineering attitude toward child
Enuresis	14	7	7	6	6	9	5	3	5
Need of surgical or medical care	10	4	12	10	6	12	1	8	2
Negativism	12	8	10	11	6	6	7	4	1
Temper tantrums	18	6	12	4	3	3	3	5	3
Food	14	10	3	1	6	4	6	6	5
Emotional dependence on adults	10	7	6	10	4	3	10	7	1
Poor nutrition	10	5	12	10	3	6	4	10	3
All problems studied	10	8	7	7	6	6	5	5	5

* For the full list of undesirable parental attitudes and practices in the parents of the problem children, see Table 12. Since the case history blanks used by the clinics did not provide for a statement of these attitudes and practices, the material used representing, rather, occasional comments made by the examiners in the case histories, the data of this table are not as reliable as those of the other tables of the study.

Table 61 shows that, in relation to the age position of the problem child in the family, the percentages of children presenting each of the seven problems are irregular in all cases but one (*emotional dependence on adults*, for the "older or oldest child" group, where the percentage is at the expected). This irregularity varies from 12 below the expected percentage (34) for *food* in the "younger or youngest child" group to 13 above the expected percentage (36) for *food* in the "only child" group. For all seven problems combined, the variation is 12 above the expected percentage for the "only child" group; 3 above for the "younger or youngest child" group; 30 below for the "between older and younger children" group; and

23 above for the "older or oldest child" group. These data indicate that, in relation to these seven problems, the frequency of occurrence is least in the "between older and younger children" group, and greatest in the "older or oldest child" group.

TABLE 61

PERCENTAGE OF CHILDREN PRESENTING EACH OF THE SEVEN PROBLEMS OF MOST FREQUENT OCCURRENCE, IN RELATION TO THE AGE POSITION OF THE PROBLEM CHILD IN THE FAMILY

PROBLEM	AGE POSITION OF PROBLEM CHILD			
	Only child	Younger or youngest child	Between older and younger children	Older or oldest child
Enuresis	30	37	18	15
Need of surgical or medical care	40	40	12	8
Negativism	42	33	19	6
Temper tantrums	27	35	20	18
Food	49	22	24	5
Emotional dependence on adults	28	36	22	14
Poor nutrition	48	30	20	2
All problems studied	36	34	16	14

TABLE 62

PERCENTAGE OF CHILDREN PRESENTING EACH OF THE SEVEN PROBLEMS OF MOST FREQUENT OCCURRENCE, IN RELATION TO THE NUMBER OF CHILDREN IN THE FAMILIES

PROBLEM	NUMBER OF CHILDREN IN THE FAMILY								
	1	2	3	4	5	6	7	8	9
Enuresis	30	34	18	9	5	4	0	0	0
Need of surgical or medical care	40	39	14	3	3	1	0	0	0
Negativism	42	38	10	4	4	0	1	0	1
Temper tantrums	27	41	14	8	6	2	1	0	1
Food	49	33	10	5	3	0	0	0	0
Emotional dependence on adults	28	39	16	12	2	2	2	0	0
Poor nutrition	48	34	8	4	4	2	0	0	0
All problems studied	36	35	15	8	3	2	1	0	0*

* Since the one case each of *negativism* and *temper tantrums* coming from a family of nine children is but 1 per cent of the total number of cases of each problem, and no cases of the other problems came from families having nine children, the percentage for all problems studied is represented by 0.

Table 62 shows that, in relation to the number of children in the families of the problem children, the percentages of children presenting each of the seven problems are irregular in the greater number of cases. This irregularity varies from 9 below the expected percentage (36) for *temper tantrums* in the "one child in the family" group to 13 above the expected for *food* in the same group. For all seven problems combined, the variation is 12 above the expected percentage for the "one child in the family" group; 13 above for the "two children in the family" group; 15 below for the "three children in the family" group; 11 below for the "four children in the family" group; 6 above for the "five children in the family" group; 1 above for the "six" and "seven children in the family" groups; and 2 above for the "nine children in the family" group. None of the cases came from families having eight children. These data indicate that, in relation to these seven problems, the frequency of occurrence is greatest in the "three children in the family" group, and least in the "two children in the family" group.

SUMMARY OF FINDINGS CONCERNING THE SEVEN PROBLEMS OF MOST FREQUENT OCCURRENCE

Enuresis. Of the 53 different types of problems treated by the clinics, *enuresis* was of most frequent occurrence, with 79 cases for the total number of children. It is the problem of most frequent occurrence (47 cases) with the boys studied. With the girls studied, however, the problem ranks fifth in frequency of occurrence (32 cases), with *negativism* (43 cases), *need of surgical or medical care* (40 cases), *food problems* (35 cases), and *emotional dependence on adults* (35 cases), respectively, ranking higher in frequency (see Table 2).

The age range for the problem is from 1 to 5 years for both boys and girls. The mode for boys is 11, between 3 and 3½ years; and for girls, 9, between 4 and 4½ years. The mean age for boys is 3.06 years; for girls, 3.31; and for both, 3.16 (see Table 16). These mean ages are less than that for all problems studied (see Table 46).

Of the children treated for this problem, a larger percentage of boys than girls were in the "above average" and "below average" mental level groups, with the least difference in the "below average" group (see Table 17).

With reference to the time of occurrence of enuresis in the 24-hour day, 51.9 per cent of the children were treated for nocturnal

enuresis, 5 per cent for diurnal enuresis, and 43 per cent for both. A larger percentage of boys than girls were treated for diurnal and for diurnal and nocturnal enuresis, with the least difference between the sexes in the diurnal division (see Table 18).

Of the 47 cases of *enuresis* among the boys, 23 were referred to and 24 discovered by the clinics; of the 32 cases among the girls, 19 were referred to and 13 discovered by the clinics (see Table 19). These facts indicate either that the parents of the children were not aware that the problem represented one of training at these ages, or that they were ashamed of it and unwilling to suggest that it was present.⁹

For boys, the coefficients of association for *enuresis* and each of the other thirteen problems of most frequent occurrence show a tendency toward complete association in one instance—that of *fear*, where the coefficient is $+0.5$ (see Table 48). For girls, these coefficients show little tendency toward association; a tendency toward dissociation is shown in two instances, i.e., with *poor nutrition*, where the coefficient is -0.7 , and with *too much attention from adults*, where the coefficient is -0.5 ; and complete dissociation in one instance—that of *too little opportunity to play with children*, with a coefficient of -1.0 (see Table 49). For the total number of cases, there is no coefficient of more than ± 0.4 (see Table 50).

That there is a sex difference in the problem is indicated by the data shown in Table 54. The chances are "favorable" that the differences between the sexes of $+1.9\sigma$ in the "above average" mental level group and -1.7σ in the "average" mental level group are not due to errors of sampling alone. In the "below average" group, the slight difference ($+0.2\sigma$) is probably due to errors of sampling.

The percentage of cases of *enuresis* is 3 above the expected for children of American-born parentage and 3 below for those of foreign-born parentage (see Table 55).

With reference to the relation of the problem to the educational training of the parents, the percentage is 4 above the expected in the "elementary school" group; 7 below in the "high school" group; 1 above in the "college and postgraduate" group; and 2 above in the "no data" group (see Table 57).

In relation to the occupational level of the fathers, the percentage of occurrence of the problem is 10 above the expected in

⁹ On this point, see "Enuresis as a Psychological Problem," by Helen T. Woolley, in *Mental Hygiene*, X, 1 (January, 1926), p. 38.

the "unskilled" group; 3 below in the "semiskilled" group; 2 above in the "skilled" group; 5 below in the "retail dealers" group; 4 below in the "executives" group; and at the expected in the "professional" group (see Table 58).

In relation to the rating of the homes of the children, the percentage of occurrence of the problem is 3 above the expected for "poor" homes; 6 above for the "fair" homes; 4 below for the "good" homes; and 5 below for the "superior" homes (see Table 59).

The percentage of occurrence of the problem with reference to the age position of the problem child in the family is 6 below the expected in the "only child" group; 3 above in the "younger or youngest child" group; 2 above in the "older or oldest child" group; and 1 above in the "between older and younger children" group (see Table 61).

In relation to the number of children in the families of the problem children, the percentage of occurrence of the problem is 6 below the expected in the "one child in the family" group; 1 below in the "two children in the family" group; 3 above in the "three children in the family" group; 1 above in the "four children in the family" group; 2 above in the "five children in the family" group; and 2 above in the "six children in the family" group (see Table 62).

Need of Surgical or Medical Care. *Need of surgical or medical care* ranks second (as does *negativism*) in frequency of occurrence, with 77 cases for the total number of children. The problem ranks third in frequency of occurrence with the boys studied, with 37 cases. It ranks second with the girls, with 40 cases; *negativism*, which ranks higher in frequency of occurrence, is represented by 43 cases (see Table 2).

The age range for the problem is from 1 to 5 years for both boys and girls. For boys, the mode is 7, at 2 to 2½ years, 2½ to 3 years, and 4½ to 5 years; for girls, 11, between 3½ and 4 years. The mean age for boys is 3.24 years; for girls, 3.4; and for both, 3.32 (see Table 20). These mean ages are less than that for all problems studied (see Table 46).

Of the children treated for this problem, a larger percentage of girls than boys were in the "above average" and "average" mental level groups. The greatest difference between the sexes is in the "below average" group, where the percentage of boys is higher than the percentage of girls, and the least difference in the "above average" group (see Table 21).

For boys, the coefficients of association of the *need of surgical or medical care* and each of the other thirteen problems of most frequent occurrence show a tendency toward complete association in two cases—that of *poor nutrition*, where the coefficient is $+0.7$, and that of *too little opportunity to play with children*, where the coefficient is $+0.6$ (see Table 48). For girls, these coefficients show a tendency toward complete association of the problem with *too little opportunity to play with children*, where the coefficient is $+0.5$, and a tendency toward complete dissociation with *thumb- or finger-sucking*, with a coefficient of -0.5 (see Table 49). For the total number of cases, these coefficients show a tendency toward complete association in two instances, i.e., with *poor nutrition* and *too little opportunity to play with children*, with the coefficient $+0.5$ in each case (see Table 51).

That there is a sex difference in the problem is indicated by the data shown in Table 54. The chances are “high” that the difference between the sexes of $+2.6\sigma$ in the “below average” mental level group, and “favorable” that the difference of -1.5σ in the “average” mental level group, are not due to errors of sampling alone. In the “above average” group, the slight difference ($+0.5\sigma$) is probably to be explained by errors of sampling (see Table 54).

The percentage of cases of *need of surgical or medical care* is 2 above the expected for children of American-born parentage and 2 below for those of foreign-born parentage (see Table 55).

With reference to the relation of the problem to the educational training of the parents, the percentage is 4 below the expected in the “elementary school” group; 3 above in the “high school” group; at the expected in the “college and postgraduate” group; and 1 above in the “no data” group (see Table 57).

In relation to the occupational level of the fathers, the percentage of occurrence of the problem is 5 below the expected in the “unskilled” group; 1 below in the “semiskilled” group; 3 above in the “skilled” group; 1 above in the “retail dealers” group; 10 above in the “executives” group; and 2 above in the “professional” group (see Table 58).

In relation to the rating of the homes of the children, the percentage of occurrence of the problem is 3 below the expected for the “poor” homes; 1 above for the “fair” homes; at the expected for the “good” homes; and 2 above for the “superior” homes (see Table 59).

The percentage of occurrence of the problem with reference to the position of the problem child in the family is 4 above the expected in the "only child" group; 6 above in the "younger or youngest child" group; 4 below in the "older or oldest child" group; and 4 above in the "between older and younger children" group (see Table 61).

In relation to the number of children in the families of the problem children, the percentage of occurrence of the problem is 4 above the expected in the "one child in the family" group; 4 above in the "two children in the family" group; 1 below in the "three children in the family" group; 1 below in the "four children in the family" group; 2 below in the "five children in the family" group; and 1 below in the "six children in the family" group (see Table 62).

Negativism. *Negativism* also ranks second in frequency of occurrence, with 77 cases for the total number of children. With the boys, the problem ranks fourth in frequency of occurrence, with 34 cases. It ranks highest with the girls, with 43 cases (see Table 2).

The age range for the problem is from $1\frac{1}{2}$ to 5 years for both boys and girls. For boys, the mode is 7, between 2 and $2\frac{1}{2}$ years; for girls, 11, between 4 and $4\frac{1}{2}$ years. The mean age for boys is 3.26 years; for girls, 3.54; and for both, 3.41 (see Table 22). The mean age for boys is less than that for all problems studied, and the mean age for girls greater (see Table 46).

Of the children treated for this problem, a larger percentage of boys than girls were in the "above average" and "below average" mental level groups; the greatest difference is in the "average" group, where the percentage of girls is 12.8 higher than the percentage of boys, and the least difference is in the "above average" group (see Table 23).

For boys, the coefficients of association of *negativism* with each of the other thirteen problems of most frequent occurrence show a tendency toward complete association in two instances ($+0.5$ with *emotional dependence on adults* and with *restlessness*), and toward dissociation in three instances (-0.5 with *too little opportunity to play with children* and with *thumb- or finger-sucking*, and -0.7 with *masturbation*) (see Table 48). For girls, these coefficients show a tendency toward complete association in one instance ($+0.5$ with *too much attention from adults*) (see Table 49). For the total number of cases, the coefficients show a tendency toward complete association in one instance ($+0.5$ with *masturbation*) (see Table 50).

That there is a sex difference in the problem is indicated by the data shown in Table 54. The chances are "favorable" that the differences between the sexes of -1.1σ in the "average" mental level group and $+1.4\sigma$ in the "below average" group are not due to errors of sampling alone. In the "above average" group, the slight difference ($+0.2\sigma$) is probably due to errors of sampling.

The percentage of cases of *negativism* is 4 above the expected for children of American-born parentage and 4 below for those of foreign-born parentage (see Table 55).

With reference to the relation of the problem to the educational training of the parents, the percentage is 8 below the expected in the "elementary school" group; 4 above in the "high school" group; 6 above in the "college and postgraduate" group; and 2 below in the "no data" group (see Table 57).

In relation to the occupational level of the fathers, the percentage of occurrence of the problem is 9 below the expected in the "unskilled" group; 2 below in the "semiskilled" group; 1 above in the "skilled" group; 4 above in the "retail dealers" group; 3 above in the "executives" group; and 3 above in the "professional" group (see Table 58).

In relation to the rating of the homes of the children, the percentage of occurrence of the problem is 4 below the expected for the "poor" homes; 1 above the expected for the "fair" homes; 7 above the expected for the "good" homes; and 4 below the expected for the "superior" homes (see Table 59).

The percentage of occurrence of the problem with reference to the age position of the problem child in the family is 6 above the expected in the "only child" group; 1 below in the "younger or youngest child" group; 3 above in the "older or oldest child" group; and 2 above in the "between older and younger children" group (see Table 61).

In relation to the number of children in the families of the problem children, the percentage of occurrence of the problem is 6 above the expected in the "one child in the family" group; 3 above in the "two children in the family" group; 5 below in the "three children in the family" group; 4 below in the "four children in the family" group; 1 above in the "five children in the family" group; at the expected in the "seven children in the family" group; and 1 above in the "nine children in the family" group (see Table 62).

Temper Tantrums. *Temper tantrums* ranks third in frequency

of occurrence, with 66 cases for the total number of children. The problem ranks second in frequency of occurrence with the boys studied, with 38 cases, and fifth with the girls studied, with 28 cases (see Table 2).

The age range for the problem is from 2 to 5 years for boys and from $1\frac{1}{2}$ to 5 years for girls. For boys, the mode is 9 at $2\frac{1}{2}$ to 3 years and $4\frac{1}{2}$ to 5 years; for girls, 8, between 3 and $3\frac{1}{2}$ years. The mean age for boys is 3.48 years; for girls, 3.53; and for both, 3.5 (see Table 24). These mean ages are greater than that for all problems studied (see Table 46).

Of the children treated for this problem, a larger percentage of girls than boys were in the "above average" and "average" mental level groups; the greatest difference is in the "below average" group, where the percentage of boys treated is 15.7 higher than the percentage of girls (see Table 25).

For boys, the coefficients of association of *temper tantrums* and each of the other thirteen problems of most frequent occurrence show no tendency toward complete association (see Table 48). For girls, these coefficients show a tendency toward complete association in the case of *fear*, where the coefficient is $+0.6$, and a complete dissociation in the case of *too little opportunity to play with children*, where the coefficient is -1.0 (see Table 49). For the total number of cases, these coefficients show a tendency toward association in the case of *fear*, where the coefficient is $+0.5$ (see Table 50).

That there is a sex difference in the problem is indicated by the data shown in Table 54. The chances are "favorable" that the difference between the sexes of $+1.9\sigma$ in the "below average" mental level group is not due to errors of sampling alone. The differences of $+0.6\sigma$ in the "above average" group and -0.9σ in the "average" group, however, are probably due to errors of sampling (see Table 54).

The percentage of cases of *temper tantrums* is 8 above the expected for children of American-born parentage and 8 below for those of foreign-born parentage (see Table 55).

With reference to the relation of the problem to the educational training of the parents, the percentage is 10 above the expected in the "elementary school" group; 10 below in the "high school" group; 1 below in the "college and postgraduate" group; and 1 above in the "no data" group (see Table 57).

In relation to the occupational level of the fathers, the percentage

of occurrence of the problem is 6 above the expected in the "unskilled" group; 1 above in the "semiskilled" group; 3 below in the "skilled" group; at the expected in the "retail dealers" group; 3 below in the "executives" group; and 1 below in the "professional" group (see Table 58).

In relation to the rating of the homes of the children, the percentage of occurrence of the problem is 10 above the expected for the "poor" homes; 3 above for the "fair" homes; 5 below for the "good" homes; and 8 below for the "superior" homes (see Table 59).

The percentage of occurrence of the problem with reference to the position of the problem child in the family is 9 below the expected in the "only child" group; 1 above in the "younger or youngest child" group; 4 above in the "older or oldest child" group; and 4 above in the "between older and younger children" group (see Table 61).

In relation to the number of children in the families of the problem children, the percentage of occurrence of the problem is 9 below the expected in the "one child in the family" group; 6 above in the "two children in the family" group; 1 above in the "three children in the family" group; at the expected in the "four children in the family" group; 3 above in the "five children in the family" group; at the expected in the "six children in the family" and "seven children in the family" groups; and approximately 1 above in the "nine children in the family" group (see Table 62).

Food. *Food* problems rank fourth in frequency of occurrence, with 63 cases for the total number of children. With the boys, the problem ranks fifth in frequency of occurrence, with 28 cases, and with the girls, third, with 35 cases (see Table 2).

The age range for boys is from 2 to 5 years, and for girls, $1\frac{1}{2}$ to 5 years. For boys, the mode is 9, between $2\frac{1}{2}$ and 3 years; for girls, 7, between 4 and $4\frac{1}{2}$ years. The mean age for boys is 3.48 years; for girls, 3.49; and for both, 3.44 (see Table 26). The mean age for boys and the mean age for the total number of cases are greater than that for all problems studied; the mean age for girls is less than that for all problems studied (see Table 46).

Of the children treated for this problem, a larger percentage of boys than girls were in the "above average" and "below average" mental level groups, with the least difference between the sexes in the "below average" group (see Table 27).

For boys, the coefficients of association of *food* problems with

each of the other thirteen problems of most frequent occurrence show a tendency toward complete dissociation in the case of *restlessness*, where the coefficient is -0.5 (see Table 48). For girls, these coefficients show a tendency toward complete dissociation in the case of *speech* problems, where the coefficient is -0.6 , and complete dissociation with *too little opportunity to play with children*, where the coefficient is -1.0 (see Table 49). For the total number of cases, the coefficients show a tendency toward complete dissociation in the case of *speech*, where the coefficient is -0.5 (see Table 50).

The data shown in Table 54 indicate that there is a sex difference in the problem. The chances are "favorable" that the difference between the sexes of -1.4σ in the "average" mental level group is not due to errors of sampling alone. The differences of $+0.8\sigma$ in the "above average" and "below average" groups are probably due to errors of sampling (see Table 54).

The percentage of cases of *food* problems is 12 below the expected for children of American-born parentage and 12 above for those of foreign-born parentage (see Table 55).

With reference to the relation of the problem to the educational training of the parents, the percentage of occurrence is 1 above the expected in the "elementary school" group; 2 below in the "high school" group; 3 below in the "college and postgraduate" group; and 4 above in the "no data" group (see Table 57).

In relation to the occupational level of the fathers, the percentage of occurrence of the problem is 2 below the expected in the "unskilled" group; 4 above in the "semiskilled" group; 4 above in the "skilled" group; 2 above in the "retail dealers" group; 4 below in the "executives" group; and 4 below in the "professional" group (see Table 58).

In relation to the rating of the homes of the children, the percentage of occurrence of the problem is at the expected for the "poor" homes; 7 above for the "fair" homes; 2 below for the "good" homes; and 5 below for the "superior" homes (see Table 59).

The percentage of occurrence of the problem with reference to the position of the problem child in the family is 12 above the expected in the "only child" group; 13 below in the "younger or youngest child" group; 8 above in the "older or oldest child" group; and 1 above in the "between older and younger children" group (see Table 61).

In relation to the number of children in the families of the prob-

lem children, the percentage of occurrence of the problem is 13 above the expected in the "one child in the family" group; 2 below in the "two children in the family" group; 5 below in the "three children in the family" group; 3 below in the "four children in the family" group; and at the expected in the "five children in the family" group (see Table 62).

Emotional Dependence on Adults. *Emotional dependence on adults* ranks fifth in frequency of occurrence, with 50 cases for the total number of children. With the boys, the problem ranks sixth, with 15 cases, and with the girls, it ranks third, with 35 cases (see Table 2).

The age range is from $1\frac{1}{2}$ to 5 years for both boys and girls. For boys, the mode is 5, between 3 and $3\frac{1}{2}$ years; for girls, 10, between 4 and $4\frac{1}{2}$ years. The mean age for boys is 3.41 years; for girls, 3.5, and for both, 3.47 (see Table 28). These mean ages are all greater than that for all problems studied (see Table 46).

Of the children treated for this problem, a larger percentage of boys than girls were in the "above average" and "below average" mental level groups. The greatest difference between the sexes is in the "average" group, where the percentage of girls is 36 higher than the percentage of boys (see Table 29).

For boys, the coefficients of association of *emotional dependence on adults* and each of the other thirteen problems of most frequent occurrence show a tendency toward complete association in three instances ($+0.5$ with *negativism*, *too much attention from adults*, and *too little opportunity to play with children*), and complete dissociation with *restlessness*, where the coefficient is -1.0 (see Table 48). For girls, these coefficients show a tendency toward complete association in one instance ($+0.5$ with *too little opportunity to play with children*), and a tendency toward complete dissociation with *speech* problems, where the coefficient is -0.6 . For the total number of cases, these coefficients show a tendency toward complete association of the problem with *too little opportunity to play with children*, where the coefficient is $+0.5$, and a tendency toward complete dissociation with *speech* problems and *restlessness*, where the coefficient is -0.5 in each case (see Table 50).

The data shown in Table 54 indicate that there is a sex difference in the problem. The chances are "high" that the difference between the sexes of -2.5σ in the "average" mental level group, and "favorable" that the differences of $+1.4\sigma$ in the "above average"

and $+1.5\sigma$ in the "below average" groups are not due to errors of sampling alone.

The percentage of cases of *emotional dependence on adults* is 2 above the expected for children of American-born parentage and 2 below for children of foreign-born parentage (see Table 55).

With reference to the relation of the problem to the educational training of the parents, the percentage of occurrence is 1 below the expected in the "elementary school" group; at the expected in the "high school" group; 1 above in the "college and postgraduate" group; and at the expected in the "no data" group (see Table 57).

In relation to the occupational level of the fathers, the percentage of occurrence of the problem is 6 below the expected in the "unskilled" group; 7 above in the "semiskilled" group; 3 below in the "skilled" group; 1 above in the "retail dealers" group; 1 below in the "executives" group; and 2 above in the "professional" group (see Table 58).

In relation to the rating of the homes of the children, the percentage of occurrence of the problem is 6 below the expected for the "poor" homes; 3 above for the "fair" homes; 3 below for the "good" homes; and 6 above for the "superior" homes (see Table 59).

The percentage of occurrence of the problem with reference to the age position of the problem child in the family is 8 below the expected in the "only child" group; 2 above in the "younger or youngest child" group; 6 above in the "older or oldest child" group; and at the expected in the "between older and younger children" group (see Table 61).

In relation to the number of children in the families of the problem children, the percentage of occurrence of the problem is 8 below the expected in the "one child in the family" group; 4 above in the "two children in the family" group; 1 above in the "three children in the family" group; 4 above in the "four children in the family" group; 1 below in the "five children in the family" group; at the expected in the "six children in the family" group; and 1 above in the "seven children in the family" group (see Table 62).

Poor Nutrition. *Poor nutrition* ranks sixth in frequency of occurrence, with 50 cases for the total number of children. The problem ranks fifth in frequency of occurrence with the boys studied, with 28 cases, and sixth for the girls, with 22 cases (see Table 2).

The age range is from 1 to 5 years for boys and from $1\frac{1}{2}$ to 5 years for the girls. For boys, the mode is 6, between $2\frac{1}{2}$ and 3

years; for girls, 4, at $2\frac{1}{2}$ to 3 years, 4 to $4\frac{1}{2}$ years, and $4\frac{1}{2}$ to 5 years. The mean age for boys is 3.28 years; for girls, 3.39; and for both, 3.33 (see Table 30). These mean ages are all less than that for all problems studied (see Table 46).

Of the children treated for this problem, a larger percentage of boys than girls were in the "average" and "below average" mental level groups. The greatest difference occurs in the "average" mental level group, where the percentage of boys is 11.6 greater than the percentage of girls (see Table 31).

For boys, the coefficients of association of *poor nutrition* with each of the other thirteen problems of most frequent occurrence show a tendency toward complete association with *need of surgical or medical care*, where the coefficient is $+0.7$, and with *too little opportunity to play with children*, where the coefficient is $+0.6$ (see Table 48). For girls, these coefficients show a tendency toward complete dissociation with *enuresis*, where the coefficient is -0.6 , and with *masturbation*, where the coefficient is -0.5 (see Table 49). For the total number of cases, a tendency toward complete association is shown in the case of *need of surgical or medical care* and *too little opportunity to play with children*, with the coefficient $+0.5$ in both instances (see Table 50).

That there is a sex difference in the problem is indicated by the data shown in Table 54. The chances are "high" that the difference between the sexes of $+2.1\sigma$ in the "above average" mental level group, and "favorable" that the difference of $+1.5\sigma$ in the "below average" mental level group, are not due to errors of sampling alone. It is probable that the difference of $+0.8\sigma$ in the "average" mental level group is accounted for by errors of sampling.

The percentage of cases of *poor nutrition* is 5 above the expected for children of American-born parentage and 5 below for those of foreign-born parentage (see Table 55).

With reference to the relation of the problem to the educational training of the parents, the percentage is 3 above the expected in the "elementary school" group; 5 above in the "high school" group; 6 below in the "college and postgraduate" group; and 2 below in the "no data" group (see Table 57).

In relation to the occupational level of the fathers, the percentage of occurrence of the problem is 14 below the expected in the "unskilled" group; 9 below in the "semiskilled" group; 5 below in the "skilled" group; 11 above in the "retail dealers" group; 5 above in

the "executives" group; and 6 below in the "professional" group (see Table 58).

In relation to the rating of the homes of the children, the percentage of occurrence of the problem is 4 below the expected for the "poor" homes; 3 above the expected for the "fair" homes; 1 above for the "good" homes; and at the expected for the "superior" homes (see Table 59).

The percentage of occurrence of the problem with reference to the age position of the problem child in the family is 12 above the expected in the "only child" group; 4 below in the "younger or youngest child" group; 4 above in the "older or oldest child" group; and 12 below in the "between older and younger children" group (see Table 61).

In relation to the number of children in the families of the problem children, the percentage of occurrence of the problem is 12 above the expected in the "one child in the family" group; 1 above in the "two children in the family" group; 7 below in the "three children in the family" group; 4 below in the "four children in the family" group; 1 above in the "five children in the family" group; and at the expected in the "six children in the family" group (see Table 62).

CHAPTER IV

THE INFLUENCE OF THE HOME ON CHILDREN'S PROBLEMS, AS SEEN BY SPECIALISTS

Three distinct kinds of problems are presented by the children studied in the present investigation, i.e., physical problems, including *need of surgical or medical care, poor nutrition, and poor motor control*; social problems, including *too little opportunity to play with children and too much attention and interference from adults*; and emotional problems, including *negativism, temper tantrums, and jealousy*.

Pediatricians, social workers, sociologists, psychiatrists, psychologists, and specialists in mental hygiene believe that many or all of the problems presented are within the control of the parents.

Although parents may not be capable of making decisions with reference to the surgical or medical care their children need, they are responsible for getting in touch with specialists who can make such decisions. Further, the training they have given the child influences the success of the pediatrician's treatment. Dr. N. M. MacNeill, Philadelphia pediatrician, considers the training the child has received from his parents of vital importance in determining the success or failure of the pediatrician's efforts. In an article on "Good and Bad Children," in the *Archives of Pediatrics*, he writes as follows:

The fact becomes appallingly evident that the failures which we so often encounter in attempting management and treatment of child patients are the direct result of failure on the part of the parent to properly mould the developing personality of the child; failure to so trim the edges of that personality in its growth, that it may not be in continuous conflict with its environment—in a word that it may not be a "bad" child.

Assuming then a normal mentality, a child becomes "good" or "bad" almost in direct accordance with parental fitness or unfitness to establish adequate disciplinary control and only to an extent largely determined by that "goodness" or "badness" is the pediatrician successful in his efforts.¹

Specialists consider the parents responsible also for the home environment, which so largely determines the child's social and emo-

¹ XLIV, 7 (July, 1927): 440.

tional behavior. Dr. Lewellys F. Barker, Emeritus Professor of Medicine in Johns Hopkins University, writes:

On the psychic and social sides of the development of the child, the family and the servants in the family come first into consideration. Then come, I think, the neighbors, the neighboring children especially; then the school; then the church and other associations into which the child enters. Then there are books, plays, moving-picture shows, theatres and things of that sort to be borne in mind. I put the family first because I believe that is the most important factor, and it is in its influence that most mistakes, perhaps, are made, and in it much can be done to improve conditions.²

In *Childhood: The Golden Period for Mental Hygiene*, Dr. William A. White, Superintendent of St. Elizabeth Hospital, Washington, D.C., emphasizes the importance of the child's early home environment in determining later responses. He writes:

An understanding of the nature of the child's relations to its environment, particularly its personal environment and specifically to the members of the family, is also essential. Its relation to the family situation begins from the moment of birth, and from the symptoms that later develop in the psychoses we have come to learn how important those relations are for conditioning the later reactions for better or worse.³

Dr. John E. Anderson, Director of the Institute of Child Welfare at the University of Minnesota, and Dr. Josephine C. Foster found it difficult to study the problems of children without studying their home environment, as noted in *The Young Child and His Parents*:

Although our original purpose in collecting the hundred cases presented hereafter was to study the normal young child and to gain some insight into the types of reaction which he shows, it became increasingly apparent as we proceeded that what we were studying was a series of home situations, in which the parents played a most important part. The young child is not a thing detached and apart from his home but is very much part and parcel of that environment. In a very real sense, he can be said to mirror the home situation. His difficulties, problems, and modes of response are not exclusively the product of his own nature but are also the result of the stimulation which he is receiving from his environment.⁴

Sybil Foster, Chief Social Worker of the Habit Clinics of the Women's Municipal League in Boston, found that the behavior for which children were referred to the clinics was usually a natural

² *How to Avoid Spoiling the Child*, p. 4.

³ Page 5.

⁴ Page 7.

response to their home environment. In *Personality Deviations and Their Relation to the Home*, she writes:

In studying 1,000 children known to the habit clinics in Massachusetts, we have been continually impressed with the fact that habits or conduct reported as alarming or annoying are, time after time, only a natural response to the stimuli these children have received from their home setting.⁵

Again, Dr. Ralph P. Truitt, Director of the Division on Prevention of Delinquency of the National Committee for Mental Hygiene, places the responsibility for children's problems squarely on the home. He writes as follows:

For the most part children's problems originate in the home, school or community and it is the various ramifications of problems encountered in these situations that handicap us in treatment. It is an established fact that children may become behavior problems because of conflicts arising from home situations in which quarreling, disagreement in discipline and other incompatibilities exist between parents. Difficulties with brothers and sisters arising from favoritism, jealousy, etc., are sometimes factors. Sex curiosity, exposure, enuresis, masturbation and other sex experiences badly handled by parents frequently contribute to mental conflicts. Lack of habit training in such simple routine matters as eating, sleeping, and playing, inconsistent discipline, and poor example, may be the starting point for serious trouble. Physical ill-health associated with fatigue, encephalitis, endocrine dysfunction, and other disorders, may contribute to unusual behavior reactions. Social inadequacy, illness in the family, industrial depression and strikes may cause stress in the home and this may have a direct bearing on the beginning of behavior problems in children.⁶

Dr. D. A. Thom, Director of the Division of Mental Hygiene of the Massachusetts Department of Mental Diseases and Instructor in Psychiatry of the Harvard Medical School, speaks of the home as "the workshop in which the personality of the child is being developed," and where "the personalities of the parents will make up, to a very large extent, the mental atmosphere in which the child has to live." He believes further that

This mental atmosphere may easily become contaminated and quite as dangerous to the mental life of the child as scarlet fever or diphtheria would be to his physical well-being. Faulty habits are invariably due to the imitation of bad examples. Yet one is quite safe in saying that the imitation of the bad example is frequently not so dangerous to the child's mental life as the way in which the indiscretion is treated by the parent.⁷

⁵ Page 1.

⁶ *Team Work in the Prevention of Crime*, p. 12.

⁷ *Habit Clinics for the Child of Preschool Age*, p. 15.

Much the same point is made by Dr. E. R. Groves, Research Professor in Sociology at the University of North Carolina, who emphasizes the importance of the parent and the home as an originating source of stimulation to the young child, as follows:

It is just here that the parent comes to have such a determining influence since, by manipulating stimulation, he partially controls the environment from which the child gets his desires, and the parent is himself in no inconsiderable degree the child's environment. The younger the child, the more the parent means as an originating source of stimulation.⁸

The parents' rôle of furnishing behavior patterns for their children is pointed out by Dr. Bernard Glueck, Lecturer in Psychiatry in the College of Physicians and Surgeons, Columbia University, in the following paragraph:

Beyond the parental functions of a biological character which are to insure for the child a good heritage, and those of an economic nature which have to do with assuring the child's physical needs, there are others, equally important and more difficult of fulfillment. They have to do with the parents' own lives as human beings, which constantly furnish a source of imitation and identification for the child.⁹

That the child may suffer from parental overanxiety and over-conscientiousness, as well as from neglect, is not to be overlooked. Dr. Thom holds that "one of the most pernicious influences to which a child is subjected is that of persistently interfering members of the family group."¹⁰

Specialists believe that parents must be responsible also for the emotional environment in which the child lives. In the opinion of Dr. Thom the parent himself must have emotional stability before he can deal with the child's emotional problems. He writes: "There is no more important aspect of the problem of child training than that of aiding parents to solve their own emotional difficulties before attempting the guidance of their offspring."¹¹ Similarly, Dr. Frankwood E. Williams, Medical Director of the National Committee for Mental Hygiene, points out the complexity and interrelations of the emotional problems of the parent and child as follows:

It is a commonplace in the child-guidance clinics that frequently it is not the children who are brought to the clinic who need treatment, but the parents

⁸ *Social Problems of the Family*, p. 218.

⁹ "Significance of Mental Hygiene and Child Guidance," *Annals of the American Academy of Political and Social Science*, 120-122 (September, 1925): 59.

¹⁰ *Habit Clinics for the Child of Preschool Age*, p. 17.

¹¹ *Mental Health of the Child*, p. 7.

who bring them. Dr. Thomas W. Salmon suggested some time ago that it probably was not so much children's clinics that were needed as "parentoria," where parents could be made over. These parents are themselves, of course, the product of a similar state of affairs. Faced now with the complexities of adult life, they have only the emotional tools forged by chance during their own childhood with which to meet them. Even under the best circumstances, therefore, it is not surprising that the emotional problems of the child often become inextricably mixed with the emotional problems of the parent.¹²

Dr. Marion E. Kenworthy, psychiatrist of the New York School of Social Work, expresses herself similarly:

It is difficult always to remember that these children are like sensitive pieces of litmus paper, strangely capable of sensing the emotional elements present in the parent, even though verbally unexpressed.¹³

The healthy adjustment of the child depends primarily upon the emotional environment of the home, in the opinion of Dr. Esther L. Richards, of the Henry Phipps Psychiatric Clinic of Johns Hopkins Hospital. She writes:

The healthy adjustment of childhood does not depend upon physician or psychologist or teacher, but upon the atmospheric conditions of the home. Science and education are but the handmaids of parental love, and as servants they cannot be above their lord.¹⁴

Dr. L. G. Lowrey, Director of the Institute for Child Guidance, New York City, notes the importance of the emotional situation in the home in influencing child behavior, and the difficulty of correcting an undesirable emotional environment. He writes as follows:

The most important and intimate contacts occur in the family, and measures directed toward changing the attitude of the family, or of any of its members, toward the child are the most difficult of all to apply. . . . Careless parents, quarrelsome parents, poorly behaved parents—all these have their effect upon the child and his behavior, and to counteract that effect is often amazingly difficult. The influence of many minor things that go to make up the general atmosphere of the home is frequently unrecognized, but this atmosphere is often of prime importance in determining the child's behavior. To correct such situations requires the utmost tact in suggestion and a great interest in coöperation on the part of the parents.¹⁵

Specialists further agree that it is often the parent, not the child, who presents the real problem. Of the need for re-educating the

¹² *Mental Hygiene and the College Student*, p. 7.

¹³ "Mental Health in Childhood," *Mental Hygiene*, X, 2 (April, 1926): 248.

¹⁴ *Practical Aspects of Parental Love*, p. 17.

¹⁵ *A Child Guidance Clinic*, p. 10.

parent before attempting to change the behavior of the child, Sybil Foster writes:

The major part of mental hygiene work with children of preschool age must necessarily be that of parental education. The beginnings of maladaptation must be detected and studied in the home and by the parents. We may offer advice and suggestions, but if we fail to make the parents understand their value, we can make little headway with the child.¹⁶

Dr. N. M. MacNeill, in the light of experience in child guidance clinics, concludes that not only the parents who seek help from the clinics, but others as well, need training in the principles of child guidance. In "Good and Bad Children" he writes:

Child Guidance Clinics are available for the child who becomes a definite "problem," and those of us who review large numbers of children from day to day, are forced to the conclusion that the principles of guidance need application, not only in the "problem" child, but in the vast majority of the little patients of our clinics; forced to the conclusion that the real problem is often the parent.¹⁷

At the Consultation Center of the Merrill-Palmer School, according to the 1925 *Report*, "it was apparent that many of the cases presented problems of parental education as well as the re-education of the child."¹⁸ Dr. John E. Anderson of the Institute of Child Welfare at the University of Minnesota finds that the problem of correcting the child's behavior, in the greater number of cases brought to the clinic, involves teaching the parent how to deal with the situation. He writes:

No one can read the cases presented in this monograph without having the conclusion forcibly driven home that the problem of correcting the child is not entirely a problem of changing the child's reaction but frequently involves the problem of educating the parent with reference to his handling of the situation. Instance after instance occurs in which the disinterested on-looker would recognize the difficulty as one due to a parental reaction of which the parent was perhaps unaware.¹⁹

Dr. Ralph P. Truitt describes the problem of the social worker and psychiatrist in dealing with problem children as one of educating the parents to the modern point of view in child management. In *Team Work in Prevention of Crime*, he writes as follows:

¹⁶ "Coöperation Between Habit Clinics and a Public Health Nursing Organization," *The Public Health Nurse*, XX, 4 (April, 1928): 176.

¹⁷ "Good and Bad Children," *Archives of Pediatrics*, XLIV, 7 (July, 1927): 439.

¹⁸ *Sixth Annual Report, Merrill-Palmer School of Homemaking*, 1925, p. 49.

¹⁹ *The Young Child and His Parents*, p. 7.

On the whole, parents have little idea of wholesome discipline and authority. As a matter of fact, the average parent has had little opportunity to acquire the modern point of view. Narrow religious concepts, old-fashioned educational backgrounds and the average family's relationships are all opposed to dealing in a scientific way with the problems of the child. Many parents believe their children's problems are trivial and an expectation that they will "outgrow" these traits prevails. "Spare the rod and spoil the child" has not been replaced in the family code by an attempt to understand the child and his needs. It is with these problems the social worker and psychiatrist are coping in an effort to remedy the individual home situations from which problem children come by putting over a psychiatric point of view to parents about themselves and their children.²⁰

Bertha C. Reynolds of the Massachusetts Division of Mental Hygiene believes that it is the parents' lack of knowledge of the simplest principles of child training that necessitates the greater part of the work of the habit clinics. In reporting a study of four hundred habit clinic children, she writes:

This study reveals a tremendous educational problem. If more than half the parents of these children were too ignorant to live understandingly in the world of common life, if 80.5 per cent of the children failed to find adequate home care, including training in conduct for living with other people, what can be done about it? Almost universally the parents were ignorant of some of the simple, commonsense principles of child training. In addition to trying to furnish a skilled diagnosis of what the real trouble might be underneath a bewildering complex of symptoms, the clinic was kept busy teaching such simple ideas as: "You cannot lie to your child and expect him to go on believing you," or "Bribing is only payment for wrong doing," or "Fear controls for a little while, but either hardens the child or makes a coward of him in the end." These ideas ought to be as much a part of common knowledge as the use of milk for babies, and, if they were, would make a large part of the habit clinic work unnecessary.²¹

Dr. Blanchard and Dr. Paynter, psychologists of the Philadelphia Child Guidance Clinic, show the interrelations of the child's behavior problems and the parents' deficiencies, and comment upon the difficulty of teaching the parent to apply general principles of child training to each new problem as it arises. In *Changing the Child's Behavior*, they write as follows:

Studies made in various parts of the country, report that from 65 per cent to 75 per cent of children with behavior difficulties have come from homes in which the parental training was markedly at fault in some respect.

²⁰ Page 14.

²¹ "Environmental Handicaps of Four Hundred Habit Clinic Children," *Hospital Social Service*, XII, 6 (December, 1925): 336.

Harsh disciplinary measures, inconsistency, and overindulgence all have their bad effects on character formation. Disharmony between parents is often projected into the child's life with disastrous results. Imitation of parental attitudes, as in the case of the child who becomes antisocial in reflection of his mother's paranoid ideas (of persecution), is often a factor in misconduct. Even more common is the imitation of psycho-neurotic tendencies of parents by children who whine and complain of physical ills although actually in excellent condition.

Since the child's misconduct is so often a reaction to his home situation, one of the first steps toward changing the child's behavior is to induce a change of behavior in his parents.

To a great extent, the success of efforts to change the child's behavior depends upon the stamina of the parents, upon their intelligent grasp of the situation, the sympathy for the child's position which can be created in them, and the initiative which they show in working out specific details of a general plan. It is no small task to turn the focus of the parents' emotions from wounded self-esteem and vanity (for just as they identify themselves with the child in that proportion they are hurt by his misconduct) to an understanding of and sympathy with the child. Nor is it always easy for the father and mother to really assimilate the suggestions which they receive, so that they carry these general principles over into each new situation as it arises. Yet the success or failure of their dealings with the child depends in large measure upon this aspect of their attitude toward him.²²

Sybil Foster, of the Boston Habit Clinics, and Dr. S. K. Smith, a psychiatrist of Oakland, California, find that merely improving the home situation often solves the child's problem. The former writes that "the encouraging thing is, that with so slight a change in adult attitudes we get immediate response in the changed conduct of the child,"²³ and Dr. Smith states that "in many of our cases the cleaning up of the home situation automatically clears up the habit situation."²⁴

In view of this close relation between the child's behavior and satisfactory adjustment and the home situation, Dr. Thom advises all child training agencies outside the home to seek parental coöperation in their programs. In *The Mental Health of the Child*, he writes:

It is essential that physicians, teachers, and the various social organizations which are making efforts to alter the conduct of children should seek diligently to obtain parental coöperation. In schemes for child training the importance of parental coöperation has been frequently ignored. To be sure, emphasis on such coöperation has sometimes been negative, that is, that some

²² Pages 5-6.

²³ "The Training and Readjustment of Young Children," *Hospital Social Service*, XVI, 6 (December, 1927): 494.

²⁴ "The Habit Clinic for the Pre-School Child," *California and Western Medicine*, 23, 2 (February, 1925): 173.

children survive with mental health in spite of their parents; but the real contribution which the father or mother can make, and how such a contribution can be brought about has, on the whole, been much neglected. We shall do well, therefore, to bear in mind that psychiatrists, psychologists, social workers, teachers, and other specialists concerned with child training are destined to succeed in any given plan only insofar as they have the coöperation of parents and others with whom the child is making daily contacts.²⁵

²⁵ Pages 25-6.

CHAPTER V

SUMMARY AND FINDINGS

SUMMARY

A complex of causes has given rise to an increased interest in child care and training in the past few years, and with it has come a demand for parental education. Educators have accordingly been confronted with the problem of determining what courses in child care and training, especially those dealing with the preschool years, should include. The formulation of such courses requires, of necessity, a knowledge of the problems that arise in the rearing of preschool children and an understanding of the importance of the parents' attitude toward and methods of dealing with these problems.

Purpose of the Study. The purpose of the present study was to discover:

1. The problems that arose in the rearing of 225 American-born children (110 boys and 115 girls) between the ages of one and five years who were free from physical deformity and above the feeble-minded level of intelligence, who came from many types of homes, and who were referred, for one reason or another, to one of the seven habit clinics whose records form the basis for the study. To discover, further: The relation between the problems and the chronological ages and mental levels of the children; the relation between the problems and the nationality, educational training, and religion of the parents, and the occupation of the fathers of the children, and the rating of their homes; and the relation between the problems and the number of children in the family and the age position of the problem child in the family.

2. The opinions of specialists concerning the importance of the parents' attitude toward and manner of dealing with their children's problems.

This information, it is hoped, will add to the knowledge upon which parental education courses are based.

Source of Data. The records of the following seven habit clinics

are the source of the data concerning the problems that arose in the rearing of 225 children of preschool age: Habit Clinics for Children, Massachusetts Department of Mental Diseases, Boston; Child Guidance Clinic of Cleveland; Behavior Clinic of the City Board of Health, Detroit; Consultation Center of the Merrill-Palmer School, Detroit; Educational Clinic of the Institute of Child Welfare Research, Teachers College, Columbia University; and Habit Clinic of the Monmouth County Social Service Organization, Red Bank, New Jersey.

Various publications—books, bulletins, and periodicals—are the source of the data concerning the opinions of specialists with reference to the importance of the parents' attitude toward and manner of dealing with their children's problems.

FINDINGS

The Problems Presented. Physical, social, and emotional problems were presented by the 225 children treated by the seven habit clinics. Fifty-three different types of problems occurred. Of the 903 cases of these problems, 431 were presented by the 110 boys of the study, and 472 by the 115 girls.

The age range was from 1 to 5 years for both boys and girls. The mean age for boys was 3.31 years; for girls, 3.44 years; and for the total number of cases, 3.37 years. The "above average" and "average" mental level groups included a larger percentage of girls than boys.

Parents and Families of the Problem Children. Sixty-four per cent of the parents of the children were American-born; 36 per cent were foreign-born. The latter represented twenty-two countries.

The data concerning the educational training of the parents show that 50 per cent were in the "illiterate to finishing the eighth grade" group; 27 per cent in the "high school" group; and 19 per cent in the "college and postgraduate" group.

Four types of religion were represented by the parents: the Protestant, with 42 per cent; the Roman Catholic, with 33 per cent; the Jewish, with 16 per cent; and the Greek Catholic, with 2 per cent. Seven per cent either had no preference or gave no data.

The occupations of the fathers included practically all types of work from that of the rag picker and railroad lamplighter to that of the Episcopal rector, lawyer, and college professor. Classified according to occupational level, 32 per cent were in the "unskilled"

group; 17 per cent in the "semiskilled" group; 7 per cent in the "skilled" group; 17 per cent in the "retail dealers" group; 9 per cent in the "executives" group; and 18 per cent in the "professional" group.

The seven most common undesirable parental attitudes and practices were disagreement of parents on discipline, friction between parents, nagging the child and comparing him unfavorably with other children, lax and inconsistent discipline, lack of sense of responsibility for training the child, tension between mother and child, waiting on the child too much, and bribing and deceiving the child.

Fourteen per cent of the homes of the children were rated as "superior"; 31 per cent as "good"; 33 per cent as "fair"; and 22 per cent as "poor."

Classification of the children according to their age position in the family shows that 35.6 per cent were in the "only child" group; 34.7 per cent in the "younger or youngest child" group; 12.4 per cent in the "between older and younger children" group; and 17.3 per cent in the "older or oldest child" group. Of the 225 children, 158, or 70.2 per cent, came from families with but one or two children.

ANALYSIS OF THE FOURTEEN PROBLEMS OF MOST FREQUENT OCCURRENCE

The use of Yule's *coefficient of association* in the analysis of all possible pairs of the fourteen problems of most frequent occurrence showed, for boys, a tendency toward complete association in the case of eight pairs of problems and a tendency toward complete dissociation in the case of seven pairs. For girls, these coefficients showed a tendency toward complete association in the case of six pairs, and a tendency toward complete dissociation in the case of sixteen pairs. For the total number of cases, these coefficients showed "independence" in the case of one pair of the problems, i.e., *masturbation* and *thumb- or finger-sucking*; a tendency toward complete association in the case of five pairs; and a tendency toward complete dissociation in the case of six pairs.

The chances are "favorable" that there are real sex differences in twelve of the fourteen problems at one or more of the three mental levels; two of the problems, *thumb- or finger-sucking* and *masturbation*, show little or no sex difference at any of the three mental levels.

FURTHER ANALYSIS OF THE SEVEN PROBLEMS OF MOST
FREQUENT OCCURRENCE

Further analysis of the seven problems of most frequent occurrence showed that the difference between the age ranges for boys and girls for the different problems varied from zero to one year, and that the rank order of the problems, according to frequency of occurrence, was different for boys and girls; with boys *enuresis* ranked first; with girls, *negativism*. The percentage of occurrence of the problems, in relation to the various data concerning the parents and homes of the problem children—the American or foreign birth, educational training, and occupation of the fathers, the rating of the home, the age position of the problem child in the family, and the number of children in the family—varied from 1 to 10 above and below the expected percentage. In no case were the problems limited to any one sex, age, or mental level; the problems were found in all groups, regardless of the parents' birthplace, educational training, occupation, and religion. They were found in all kinds of homes, from "superior" to "poor," and in families of from one to nine children, though the greater number of children came from families with one or two children. The problem child was found in all age positions in the family, from "only child" to "older or oldest child." The problems appear to be common to all groups of children included in this study.

In the opinion of many specialists in child care and training, the responsibility for the physical and mental health of young children must be assumed, primarily, by the parents and other adults who are with the children over long periods of time.

SUGGESTIONS FOR THE USE OF THE DATA IN PARENTAL EDUCATION

The study reveals the need of parents for information concerning child development, child training in behavior common to all children, and methods of dealing with problems of delayed training. It is suggested that the data made available by the study be used, together with similar studies and authoritative literature on the subject, to familiarize parents with the common problems of childhood. A knowledge of such material, it is believed, will serve to assist parents both in taking intelligent measures to prevent the occurrence of the problems and in treating them when they do occur.

Courses in parental education, for which the material of the

present study has been planned to serve as a partial basis, should, it is thought, consider not only the common problems of childhood, but also the effect of the parents' behavior and attitude toward the child and his problems. The discussion of undesirable parental attitudes and practices and the summary of the opinions of specialists in child care and training concerning the influence of the home on children's problems, included in the study, may be helpful in these phases of the parental education course.

A course based upon a study of such data may help parents to recognize not only the problems which usually cause most annoyance, such as feeding problems and temper tantrums, but also those which are equally important, if less tangible, such as jealousy and self-consciousness. It will also, it is believed, help parents to realize that these problems are common to childhood, and not peculiar to their own children, and will accordingly prepare them to face the problems without feeling shocked, injured, or ashamed if they need help in solving them. The large proportion of the children who showed a need of surgical or medical care will demonstrate further to parents the need for regular physical examinations of young children.

The data may be found useful in checking against those of similar studies, in order further to verify the findings in relation to these problems.

In brief, it is thought that the material may be of use in parental education courses in helping parents to prevent or to solve the problems commonly met in the rearing of young children, in encouraging them to consult specialists when they need help with these problems, and in bringing them to a realization that, though specialists may suggest changes or measures that will help them to solve these problems, the responsibility for the physical and mental health of children lies, rather, with the parents and others who are with the children over long periods of time.

SUGGESTIONS FOR FURTHER INVESTIGATION

1. Study the relation between undesirable parental attitudes and each of the problems presented by preschool children.
2. Study the problems of preschool children appearing most frequently at the different ages and mental levels.
3. Study more intensively each phase of the different problems, e.g., different fears and speech disorders.

4. Study the problems of children from "one child" families as compared with those of children from "more than one child" families.

5. Compare the problems of the "first" child in families with those of the "second" child in families.

6. Study the problems of children whose mothers have had different kinds of professional training, e.g., nurse's training and kindergarten training, to determine whether the problems are markedly different.

7. Study the relation between the number and kinds of problems referred to the clinics by parents and those discovered by the clinics.

8. Study further the problems presented by foster-children.

9. Study further the problems presented by children who have nursemaids.

10. Study further the differences in the problems presented by the children of native- and foreign-born parents.

11. Test the value of a course in parental education by comparing the problems of the preschool children of parents who have had such a course with those of the preschool children of a matched control group of parents who have not had such a course.

BIBLIOGRAPHY

BOOKS

- ANDERSON, J. E. and FOSTER, J. C. *The Young Child and His Parents*. Minneapolis: The University of Minnesota Press, 1927.
- BOWLEY, A. L. *Elements of Statistics*. New York: Charles Scribner's Sons, 1920.
- GROVES, E. R. *Social Problems of the Family*. Philadelphia: J. B. Lippincott Co., 1927.
- RIETZ, H. L. (Editor.) *Handbook of Mathematical Statistics*. Boston: Houghton Mifflin Co., 1924.
- TERMAN, LEWIS M. et al. *Genetic Studies of Genius*. Stanford University, California: Stanford University Press, 1925.
- THOM, D. A. *Mental Health of the Child*. Cambridge: Harvard University Press, 1928.
- United States Census Report*, 1920.
- WALSH, J. J. and FOOTE, J. A. *Safeguarding Children's Nerves*. Philadelphia: J. B. Lippincott Co., 1923.
- YULE, G. U. *Theory of Statistics* (6th ed.). London: Chas. Griffin & Co., 1922.

BULLETINS

- BARKER, LEWELLYS F. *How to Avoid Spoiling the Child*. National Committee for Mental Hygiene, 1922.
- BLANCHARD, PHYLLIS and PAYNTER, R. H. *Changing the Child's Behavior*. National Committee for Mental Hygiene, 1927.
- Commonwealth Fund Program for the Prevention of Delinquency, *Progress Report*. Joint Committee on Methods of Preventing Delinquency, New York, October, 1926.
- COOPER, OLIVE A. "Habit Clinics in Massachusetts." *The Commonwealth*, Vol. XII, No. 2, April-May-June, 1925.
- FOSTER, SYBIL. *Personality Deviations and Their Relation to the Home*. National Committee for Mental Hygiene, 1927.
- JARRETT, MARY C. *Mental Clinics: An Account of Their Development in the United States*. National Committee for Mental Hygiene, 1927.
- LOWREY, L. G. *A Child Guidance Clinic*. National Committee for Mental Hygiene, 1924.
- Merrill-Palmer School of Homemaking*, Fifth Annual Report, 1924.
- Merrill-Palmer School of Homemaking*, Sixth Annual Report, 1925.
- RICHARDS, ESTHER L. *Practical Aspects of Parental Love*. National Committee for Mental Hygiene, 1927.
- THOM, D. A. *Habit Clinics for the Child of Preschool Age*. United States Children's Bureau, Publication No. 135, 1924.

- THOM, D. A. "Moulding Personality in the Preschool Years." *Mental Hygiene of Normal Childhood*, A Series of Lectures Delivered in New York, January and February, 1927. Buffalo Mental Hygiene Council, 1927.
- TRUITT, RALPH P. *Team Work in the Prevention of Crime*. Joint Committee on Methods of Preventing Delinquency, November, 1926.
- WHITE, WILLIAM A. *Childhood: The Golden Period for Mental Hygiene*. National Committee for Mental Hygiene, 1925.
- WILLIAMS, FRANKWOOD E. *Mental Hygiene and the College Student*, Second Paper. National Committee for Mental Hygiene, 1925.

PERIODICALS

- ALLEN, F. H. "Your Responsibility as Parents." *Hospital Social Service*, XVII, 1: 62-7.
- CUNNINGHAM, BESS V. "The Educational Clinic as a Laboratory for Students in Training." *Teachers College Record*, XVIII, 8 (April, 1927): 814-8.
- FOSTER, SYBIL. "Coöperation Between Habit Clinics and a Public Health Nursing Organization." *Public Health Nurse*, XX, 4 (April, 1928): 173-6.
- FOSTER, SYBIL. "The Training and Readjustment of Young Children." *Hospital Social Service*, XVI, 6 (December, 1925): 485-94.
- GLUECK, BERNARD. "Significance of Mental Hygiene and Child Guidance." *Annals of the American Academy of Political and Social Science*, 120-122 (September, 1925): 53-9.
- KENWORTHY, MARION E. "Mental Health in Childhood." *Mental Hygiene*, X, 2 (April, 1926): 242-52.
- MACNEILL, N. M. "Good and Bad Children." *Archives of Pediatrics*, XLIV, 7 (July, 1927): 437-41.
- REYNOLDS, BERTHA C. "Environmental Handicaps of Four Hundred Habit Clinic Children." *Hospital Social Service*, XII, 6 (December, 1925): 329-36.
- SMITH, S. K. "The Habit Clinic for the Pre-School Child." *California and Western Medicine*, XXIII, 2 (February, 1925): 172-4.
- WITMER, LIGHTNER. "Clinical Psychology." *Psychological Clinic*, I, 1 (March 15, 1907): 1-9.
- WITMER, LIGHTNER. "The Psychological Diagnosis and the Psychonomic Orientation of Analytic Science." *Psychological Clinic*, XVI, 1-2 (January-February, 1925): 1-19.
- WOOLLEY, HELEN T. "Enuresis as a Psychological Problem." *Mental Hygiene*, X, 1 (January, 1926): 38-53.
- YULE, G. U. "On the Association of Attributes in Statistics." *Philosophic Transactions of the Royal Society*, Series A, Vol. CXCIV, 1900: 257-319.

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